Health Services
LOS ANGELES COUNTY

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES
23 March 6, 2012
SACHI A. HAMAI
EXECUTIVE OFFICER

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners

www.dhs.lacounty.gov

March 06, 2012

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF AN AMENDMENT TO CLAIMS ADJUDICATION SERVICES AGREEMENT
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval of an Amendment to the Agreement with American Insurance Administrators, a Subsidiary of Management Applied Programming, Inc., for the continued provision of claims adjudication services for the Physician Services for Indigents Program, Metrocare Physician Program, Healthy Way LA Program and the Clinic Capacity Expansion Project.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Authorize the Director of Health Services (Director), or his designee, to execute Amendment No. 4 to Agreement No. H-702685 with American Insurance Administrators, a Subsidiary of Management Applied Programming, Inc. (AIA), effective upon Board approval, to align the Agreement term with the County's fiscal year effective upon Board approval, extend the term for the period April 1, 2012 through June 30, 2014,for the continued provision of claims adjudication services for the Physician Services for Indigents Program (PSIP), MetroCare Physician Program (MPP), and the Healthy Way LA Program (HWLA)/Clinic Capacity Expansion Project (CCEP), and increase the maximum obligation in the amount of $8.73 million for the extended period.

2. Delegate authority to the Director, or his designee, to augment the maximum obligation of each program in an amount not to exceed ten percent

of the programs' individual maximum obligation for the applicable fiscal year to support any increases in claims adjudication services, i.e., increases in emergency care for uninsured indigent patients in PSIP or MPP, and/or increases in HWLA/CCEP services, subject to review and approval by County Counsel, with notice to your Board and the CEO.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of the first recommendation will allow the Director, or his designee, to execute Amendment No. 4, substantially similar to Exhibit I, to the Agreement with AIA, to align the term with the County's fiscal year, extend the term through June 30, 2014, and increase the maximum obligation by $8.73 million. The extension of this Agreement is needed to ensure that all claims continue to be adjudicated, without interruption, in accordance with the provisions of the various medical service agreements administered under the PSIP, MPP, and HWLA/CCEP. The current Agreement with AIA expires March 31, 2012.

Approval of the second recommendation will allow the Director, or his designee, to execute future amendments to this Agreement to increase the maximum obligation of each program as necessary to support increases in claims adjudication service needs for existing program initiatives. As the Department continues to increase HWLA membership and find new avenues to promote the program, it could exceed its own enrollment estimates, which may consequently result in increased claims and necessitate an amendment to this Agreement.

Implementation of Strategic Plan Goals

The recommended actions support Goal 4, Health and Mental Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The County's maximum obligation to AIA will be approximately $8.73 million for the period April 1, 2012, through June 30, 2014, partially offset by State-allocated SB 612/1773 EMS Maddy and California Department of Health Services (CDHS) Coverage Initiative funds, increasing the County's total maximum obligation under the Agreement from an estimated $12.81 million to $21.54 million. Attachment A provides additional details. This increase to the total maximum obligation is substantial, but is necessary based on the anticipated increases to the number of claims AIA will adjudicate. It is also important to note that, in addition to the offsets, the Department will benefit by replacing the fixed price per claim rate that is currently in effect with a tiered rate structure for primary care claims, and a reduced rate for pharmacy claims, under HWLA/CCEP. It is estimated that the new rates will result in a savings of up to $0.80 million per fiscal year, contingent upon increases in primary care services. Attachment B provides additional details for your reference.

Funding is included in HSA's Fiscal Year 2011-12 Final Budget and will be requested in future fiscal years.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The Department is responsible for processing claims for payment to non-County physician providers who provide services through the PSIP and MMP; as well as Community Partner claims under HWLA/CCEP. These claims adjudication services have been provided under contract with AIA for several years. The current Agreement and Amendment No. 1 were approved by your Board on

March 20, 2007, and March 25, 2008, respectively. Under delegated authority, the Department executed two subsequent amendments to increase the maximum obligation to support an increase in claims adjudication.

AIA is processing approximately 1.20 million non-County physician claims annually for County-responsible patients under the PSIP, MPP, and HWLA/CCEP. Based on DHS estimates, the annual number of claims could double during the extension period.

The Agreement specifies a maximum obligation for claims adjudication services for each program and is currently utilized by two DHS divisions; Fiscal Services - Health Services Administration for PSIP and MPP, and the Ambulatory Care Network for HWLA/CCEP.

The Agreement may be terminated for convenience by County upon 30 days' prior written notice.

The Agreement includes all Board of Supervisors' required provisions, including the following updated provisions: General Insurance Requirements, Records and Audits, Confidentiality, Waiver of Terms and Conditions, and Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

County Counsel has approved Exhibit I as to form.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will ensure claims adjudication services continue without interruption for the County's safety net programs (PSIP, MMP, HWLA/CCEP).

Respectfully submitted,

Mitchell H. Katz, M.D.

Director

MHK:jca

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

ATTACHMENT A

CLAIMS ADJUDICATION SERVICES AGREEMENT FUNDING

Agreement Funding by Period (Base Agreement thru Amendment No. 3)	PSIP and MPP	Ambulatory Care Network (formerly Office of Ambulatory Care) for PPP, HWLA, SB474 and CCEP	Totals
March 27, 2007 - March 31, 2008	$1,100,000	$1,400,250	$2,500,250
April 1, 2008 - March 31, 2009	$1,150,000	$1,329,000	$2,479,000
April 1, 2009 - March 31, 2010	$1,150,000	$1,329,000	$2,479,000
April 1, 2010 - March 31, 2011	$1,150,000	$1,528,350	$2,678,350
April 1, 2011 - March 31, 2012	$1,150,000	$1,528,350	$2,678,350
Totals	$5,700,000	$7,114,950	$12,814,950
Agreement Funding by Period (Proposed Amendment No. 4)	**PSIP and MPP**	**Ambulatory Care Network for HWLA (Matched & Unmatched) and CCEP**	**Totals**
April 1, 2012 - June 30, 2012	$350,000	$600,000	$950,000
July 1, 2012 - June 30, 2013	$1,350,000	$3,422,591	$4,772,591
July 1, 2013 - June 30, 2014	$1,350,000	$1,657,145	$3,007,145
Totals	$3,050,000	$5,679,736	$8,729,736
Grand Totals	**$8,750,000**	**$12,794,686**	**$21,544,686**

Attachment B

AIA Claims Adjudication
Estimated Savings Analysis

Primary Care Claims

Current Fee	Proposed Fee	Proposed Tiers	Estimated No of Claims	Estimated Saving
1.35	$1.35	0 to 500,000	500,000	$0
1.35	$1.10	500,001 to 750,000	250,000	$62,500
1.35	$1.00	750,001 to 1000,000	250,000	$87,500
1.35	$0.90	Over 1000,000	1,300,000	$585,000
Total			**2,300,000**	**$735,000**

Pharmacy Claims

	Current Fee	Proposed Fee	Proposed Tiers	Estimated No. of Claims	Estimated Saving
Electronic	1.35	$0.85	N/A	15,360	7,680
Manual	1.85	$1.00	N/A	61,440	52,224
Total				**76,800**	**59,904**

Contract # H-702685-4

CLAIMS ADJUDICATION SERVICES AGREEMENT

AMENDMENT NO. 4

THIS AMENDMENT is made and entered into this _____ day of _____, 2012,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and AMERICAN INSURANCE ADMINISTRATORS ("AIA"), A SUBSIDIARY OF MANAGEMENT APPLIED PROGRAMMING, INC. (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitle "CLAIMS ADJUDICATION SERVICES AGREEMENT", dated May 20, 2007, and any amendments thereto, all further identified as Agreement No. H-702685 (all hereafter "Agreement"); and

WHEREAS, it is the intent of the parties hereto to amend the Agreement to align the term with County's fiscal year, extend the term through June 30, 2014, increase the maximum obligation accordingly to support claims adjudication and programming costs for Health Services Administration and Ambulatory Care Network program needs, update the Board mandated provisions, under the current certain terms and conditions and make the changes described hereinafter; and

WHEREAS, the Agreement provides that changes to its terms may be made in the form of a written amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties hereby agree as follows:

1. This Amendment shall be effective _____..

2. Agreement Paragraph 1, TERM OF AGREEMENT, shall be replaced it in its entirety as follow:

"1. TERM OF AGREEMENT: This Agreement shall be effective April 1, 2007 and shall continue in full force and effect through June 30, 2014."

3. Agreement Paragraph , DESCRIPTION OF SERVICES, shall be replaced in its entirety with the following:

". DESCRIPTION OF SERVICES: Contractor shall provide claims processing services to County as specified in Exhibit A-1, PSIP Claims Adjudication, Exhibit B-1, Ambulatory Care Network Claims Adjudication Services, and Exhibit C-1, MPP Claims Adjudication Services, attached hereto and incorporated herein by reference, in accordance with the payment provisions and rates specified in Exhibits A-1, B-1, and C-1, and each of their respective attachments and forms, all attached hereto and incorporated herein by reference.

Additional Services to be provided by Contractor at no additional cost to County includes the creation of an electronic file format and transfer of hospital and/or patient data to the Department's Information Technology – Data and Analytics Division."

4. Agreement Paragraph 5, MAXIMUM OBLIGATION, sub-paragraph F., shall be deleted in its entirety.

5. Agreement Paragraph 5, MAXIMUM OBLIGATION, sub-paragraphs F., G., H., and I., shall be added to the Agreement as follows:

"5. MAXIMUM OBLIGATION:

F. During the period of April 1, 2012 through June 30, 2012, the maximum obligation for all Claims Processing Program services (PSIP, MPP, and Ambulatory Care Network [ACN]) provided under this Agreement shall not exceed Nine Hundred Fifty Thousand Dollars ($950,000).

(1) That portion of the maximum obligation designated for PSIP and MPP Claims Adjudication Services shall not exceed Three Hundred Fifty Thousand Dollars ($350,000) and will be offset by any available State allocated SB 612/1773 EMS Maddy funds.

(2) That portion of the maximum obligation designated for ACN Program Claims Adjudication Services shall not exceed Six Hundred Thousand Dollars ($600,000) and will be offset by Three Hundred Thousand Dollars ($300,000) in California Department of Health Services (CDHS) Coverage Initiative funds and Three Hundred Thousand Dollars ($300,000) in net County cost.

G. During the period of July 1, 2012, through June 30, 2013, the maximum obligation for all Claims Processing Program services (PSIP, MPP, and ACN) provided under this Agreement shall not exceed Four Million, Seven Hundred Seventy-Two Thousand, Five Hundred Ninety-One Dollars ($4,772,591).

(1) That portion of the maximum obligation designated for PSIP and MPP Claims Adjudication Services shall not exceed One Million Three Hundred Fifty Thousand Dollars ($1,350,000) and will

be offset by any available State allocated SB 612/1733 EMS Maddy funds.

(2) That portion of the maximum obligation designated for ACN Program Claims Adjudication Services shall not exceed Three Million, Four Hundred Twenty-Two Thousand, Five Hundred Ninety-One Dollars ($3,422,591) and will be offset by One Million Seven Hundred Eleven Thousand Two Hundred Ninety-Six Dollars ($1,711,296) in California Department of Health Services (CDHS) Coverage Initiative funds and One Million Seven Hundred Eleven Thousand Two Hundred Ninety-Five Dollars ($1,711,295) in net County cost.

H. During the period of July 1, 2013, through June 30, 2014, the maximum obligation for all Claims Processing Program services (PSIP, MPP, and ACN) provided under this Agreement shall not exceed Three Million, Seven Thousand, One Hundred Forty-Five Dollars ($3,007,145).

(1) That portion of the maximum obligation designated for PSIP and MPP Claims Adjudication Services shall not exceed One Million Three Hundred Fifty Thousand Dollars ($1,350,000) and will be partially offset by any available State allocated SB 612/1773 EMS Maddy funds.

(2) That portion of the maximum obligation designated for ACN Program Claims Adjudication Services shall not exceed One Million, Six Hundred Fifty-Seven Thousand, One Hundred Forty-Five

Dollars ($1,657,145) and will be offset by Eight Hundred Twenty-Eight Thousand Five Hundred Seventy-Three Dollars ($828,573) in California Department of Health Services (CDHS) Coverage Initiative funds and Eight Hundred Twenty-Eight Thousand Five Hundred Seventy-Two Dollars ($828,572) in net County cost."

I. For all Claims Processing Program services (PSIP, MPP, and ACN) effective April 1, 2012, in the event sufficient monies are available from Federal, State, or County funding sources, and County requires additional services, and in the event that County requires additional work from Contractor, which work shall include an unanticipated increase in the volume of claims adjudication activities, the Director, or his authorized designee may increase the applicable designated County maximum obligation for PSIP, MPP AND ACN Program Claims Adjudication services by an amount not to exceed ten percent (10%) of each year's maximum obligation for this service. Any such change in the designated County maximum obligation shall apply only to the provision of future services, shall not be retroactive and shall be effected by an amendment to this Agreement approved by the Chief Executive Office and County Counsel and executed by Contractor and Director or his authorized designee.

6. Agreement Paragraph 12, GENERAL INSURANCE REQUIREMENTS, shall be replaced in its entirety with the following:

"12. GENERAL INSURANCE REQUIREMENTS: Without limiting Contractor's indemnification of County, and in the performance of this Contract and until all of its obligations pursuant to this Contract have been met, Contractor shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in this Agreement These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other contractual obligation imposed upon Contractor pursuant to this Agreement. The County in no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Agreement.

A. Evidence of Coverage and Notice to County: Certificate(s) of insurance coverage (Certificate) satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to County at the address shown below and provided prior to commencing services under this Agreement. Renewal Certificates shall be provided to County not less than 10 days prior to Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Contractor and/or Sub-Contractor insurance policies at any time.

Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Contract by name or number, and be signed by an authorized representative of the insurer(s). The Insured party

named on the Certificate shall match the name of the Contractor identified as the contracting party in this Contract. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.

Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions. Certificates and copies of any required endorsements shall be sent to:

County of Los Angeles, Department of Health Services
Contract Administration & Monitoring
313 N. Figueroa Street, 6E, Los Angeles, CA 90012
Attention: Kathy K. Hanks, Director

Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to Contractor. Contractor also shall promptly notify County of any third party claim or suit filed against Contractor or any of its Subcontractors which arises from or relates to this Contract, and could result in the filing of a claim or lawsuit against Contractor and/or County.

B. Additional Insured Status and Scope of Coverage: The County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under Contractor's General Liability policy with respect to liability arising out of Contractor's ongoing and completed operations performed on behalf of the County. County and its Agents additional insured status shall apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is attributable to the Contractor or to the County. The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable providing it satisfies the Required Insurance provisions herein.

C. Cancellation of Insurance: Except in the case of cancellation for non-payment of premium, Contractor's insurance policies shall provide, and Certificates shall specify, that County shall receive not less than thirty (30) days advance written notice by mail of any cancellation of the Required Insurance. Ten (10) days prior notice may be given to County in event of cancellation for non-payment of premium.

D. Failure to Maintain Insurance: Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Contract, upon which County

immediately may withhold payments due to Contractor, and/or suspend or terminate this Contract. County, at its sole discretion, may obtain damages from Contractor resulting from said breach.

E. Insurer Financial Ratings: Coverage shall be placed with insurers acceptable to the County with A.M. Best ratings of not less than A:VII unless otherwise approved by County.

F. Contractor's Insurance Shall Be Primary: Contractor's insurance policies, with respect to any claims related to this Contract, shall be primary with respect to all other sources of coverage available to Contractor. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Contractor coverage.

G. Waivers of Subrogation: To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s) rights of recovery against County under all the Required Insurance for any loss arising from or relating to this Contract. The Contractor shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

H. Sub-Contractor Insurance Coverage Requirements: Contractor shall include all Sub-Contractors as insureds under Contractor's own policies, or shall provide County with each Sub-Contractor's separate evidence of insurance coverage. Contractor shall be responsible for verifying each Sub-Contractor complies with the Required Insurance provisions herein, and shall require that each Sub-Contractor name the County and

Contractor as additional insureds on the Sub-Contractor's General Liability policy. Contractor shall obtain County's prior review and approval of any Sub-Contractor request for modification of the Required Insurance.

I. Deductibles and Self-Insured Retentions (SIRs): Contractor's policies shall not obligate the County to pay any portion of any Contractor deductible or SIR. The County retains the right to require Contractor to reduce or eliminate policy deductibles and SIRs as respects the County, or to provide a bond guaranteeing Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

J. Claims Made Coverage: If any part of the Required Insurance is written on a claims made basis, any policy retroactive date shall precede the effective date of this Contract. Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following Contract expiration, termination or cancellation.

K. Application of Excess Liability Coverage: Contractors may use a combination of primary, and excess insurance policies which provide coverage as broad as (follow form) over the underlying primary policies, to satisfy the Required Insurance provisions.

L. Separation of Insureds: All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance

Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

M. Alternative Risk Financing Programs: The County reserves the right to review, and then approve, Contractor use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

N. County Review and Approval of Insurance Requirements: The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures."

7. Agreement Paragraph 16, RECORD AND AUDITS, shall be replaced in its entirety with the following:

"16. RECORDS AND AUDITS: Contractor shall maintain accurate and complete financial (including billing and eligibility) records of its operations as they relate to its services under this Agreement in accordance with generally accepted accounting principles. Contractor shall also maintain accurate and complete employment and other records of all services provided hereunder. Contractor's record retention policy for all such records shall comply with State and Federal regulations. All such records shall be retained by Contractor for a minimum period of five (5) years following the expiration or prior termination of this Agreement.

During such five (5) year period, as applicable, as well as during the term of this Agreement, all records or true and correct copies thereof pertaining to this Agreement, including but not limited to those described above, and all additional documents which bear any reasonable relationship whatsoever to this Agreement, shall be retained by Contractor at a location in Los Angeles County. Such records shall be immediately available upon request by County.

A. Audit Reports: In the event that an audit of any or all aspects of this Agreement is conducted of Contractor by any Federal or State auditor, or any auditor or accountant employed by Contractor or otherwise, Contractor shall file a copy of each such annual audit with County's Department of Auditor-Controller and Department of Health Services, Centralized Contract Monitoring Division, within thirty (30) calendar days of Contractor's receipt thereof, unless otherwise provided under this Agreement or under applicable Federal or State law. County shall make a reasonable effort to maintain the confidentiality of such audit report(s).

C. Independent Audit: Contractor's financial records shall be audited by an independent auditor for every year that this Agreement is in effect.

The audit shall satisfy the requirements of the Federal Office of Management and Budget (OMB) Circular Number A-133. The audit shall be made by an independent auditor in accordance with Governmental Financial Auditing Standards developed by the Comptroller General of the United States, and any other applicable Federal, State, or County statutes, policies,

or guidelines. Contractor shall file such audit report(s) with the County's Department of Auditor-Controller and DHS' Centralized Contract Monitoring Division, no later than ninety (90) calendar days from the completion of the audit.

The independent auditor's work papers shall be retained from a minimum of three (3) years from the date of the report, unless the auditor is notified in writing by County to extend the retention period. Audit work papers shall be made available for review by Federal, State, or County representatives upon request.

C. Audit/Compliance Review: In addition to the audit provisions of this Paragraph, County staff designated by Director, or Federal or State representatives, may conduct an audit/compliance review of all claims paid by County during a specified time period including claims and/or services provided by the subcontractor on behalf of the contractor. If the audit is conducted by County staff, any sampling shall be determined in accordance with generally accepted auditing standards, and an exit conference shall be held following the performance of such audit/compliance review at which time the results shall be discussed with Contractor. Contractor shall be provided with a copy of any written evaluation reports prepared by County staff.

If the claims review is conducted by County staff, Contractor shall have the opportunity to review County's findings for Contractor, and Contractor shall have thirty (30) calendar days after receipt of County's audit/

compliance review results to provide documentation to County representatives to resolve the audit exceptions. If, at the end of the thirty (30) calendar day period, audit exceptions remain which have not been resolved to the satisfaction of County's representatives, then the exception rate found in the audit or sample may be applied to the total County payment made to Contractor for all claims paid during the audit/compliance review period to determine Contractor's liability to County.

D. County Audit Settlements: At any time during the term of this Agreement or at any time after the expiration or earlier termination of this Agreement, authorized representatives of County may conduct an audit of Contractor regarding the services provided to County hereunder.

If Director determines at any time that Contractor has been overpaid, following Director's written notice, the amount of the overpayment shall be paid immediately by Contractor to County or recouped in the next payment cycle.

If Director determines that Contractor has been underpaid, the amount of the underpayment shall be paid within a reasonable time to Contractor. However, County shall not pay to Contractor an amount in excess of County's maximum obligation under this Agreement, except as may be expressly specified elsewhere in Agreement.

Failure of Contractor to comply with any one or more of the provisions of this Paragraph shall constitute a material breach of contract upon which County may terminate or suspend this Agreement."

8. Agreement Paragraph 29, CONFIDENTIALITY, shall be replaced in its entirety with the following:

"29. CONFIDENTIALITY: Contractor shall maintain the confidentiality of all records and information in accordance with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies concerning information technology security and the protection of confidential records and information.

Contractor shall indemnify, defend, and hold harmless County, its Special Districts, elected and appointed officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, costs and expenses, administrative penalties and fines assessed, including, without limitation, defense costs and legal, accounting and other expert, consulting, or professional fees, arising from, connected with, or related to any failure by Contractor, its officers, employees, agents, or subcontractors, to comply with this Paragraph, as determined by County in its sole judgment. Any legal defense pursuant to Contractors indemnification obligations under this Paragraph shall be conducted by Contractor and performed by counsel selected by Contractor and approved by County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide County with a full and adequate defense, as determined by County in its sole judgment, County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Contractor for all such

costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of County without County's prior written approval.

Contractor shall inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality and indemnification provisions of this Agreement.

Contractor shall provide to County an executed Contractor Employee Acknowledgement and Confidentiality Agreement, Exhibit D, and adhere to the provisions of the Contractor Employee Acknowledgement and Confidentiality Agreement, Exhibit D.

Contractor shall provide to County an executed Contractor Non-Employee Acknowledgment and Confidentiality Agreement, Exhibit D-1, for each of its non-employees performing work under this Agreement in accordance with the Independent Contractor Status Paragraph."

9. Agreement Paragraph 42, CONTRACTOR'S OBLIGATONS AS "BUSINESS ASSOCIATE" UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, shall be replaced in its entirety with the following:

"42. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA) AND THE HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH): The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing regulations. Contractor understands and

agrees that, as a provider of medical treatment services, it is a "covered entity" under HIPAA/HITECH and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information, including the use of appropriate consents and authorizations specified under HIPAA/HITECH.

The parties acknowledge their separate and independent obligations with respect to HIPAA/HITECH, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA/HITECH in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA/HITECH, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

Contractor and County understand and agree that each is independently responsible for HIPAA/HITECH compliance and agree to take all necessary and reasonable actions to comply with the requirements of the HIPAA/HITECH law and implementing regulations related to transactions and code sets, privacy, and security.

Each party further agrees that, should it fail to comply with its obligations under HIPAA/HITECH, it shall indemnify and hold harmless the other party (including the other party's officers, employees, and agents), for damages to the other party that are attributable to such failure."

10. Agreement Paragraph 62, CONTRACTOR'S OFFICES, shall be replaced in its entirety with the following:

"62. CONTRACTOR'S OFFICES: Contractor's primary business office is located at: 13191 Crossroads Parkway North, Suite 205, City of Industry, California 91746. Contractor's business telephone number is (562) 908-4567 and facsimile/FAX number is (562) 695-6105.

Contractor shall notify in writing County DHS, Ambulatory Care Network, of any change in its Executive staff, primary business or billing address, business telephone number, and/or facsimile/FAX number used in the provisions of services herein, at least ten (10) calendar days prior to the effective date thereof.

If during the term of this Agreement, the corporate or other legal status of Contractor changes, or the name of Contractor changes, then Contractor shall notify County DHS, Ambulatory Care Network, in writing detailing such changes at least thirty (30) calendar days prior to the effective date thereof. For changes in Contractor's corporate or other legal status, the consent of County thereto may be required in accordance with the ASSIGNMENT BY CONTRACTOR Paragraph, as a condition to this Agreement continuing."

11. Agreement Paragraph 63, NOTICES, shall be replaced in its entirety with the following:

"63. NOTICES: Any and all notices required, permitted, or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by U.S. mail (e.g., U.S. Priority, U.S. Express, certified or registered, return receipt requested) and, as necessary, by facsimile transmission and addressed as follows:

A. Notices to County shall be addressed as follows:

Department of Health Services
Ambulatory Care Network
1000 South Fremont Avenue, Building A-9 East 2nd Floor
Alhambra, California 91803-8859
Attn: Chief Executive Officer

B. Notices to Contractor shall be addressed as follows:

American Insurance Administrators
A Subsidiary of Management Applied Programming, Inc.
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746
Attn: President

If personally delivered, such notice shall be deemed given upon delivery. If mailed or transmitted by facsimile in accordance with this Paragraph, such notice shall be deemed given as of the date indicated on the facsimile transmission validation or U.S. mail receipt, whichever applies based on mode of transmission used. Either party may change its address for notice purposes by giving prior written notice of such change to the other party in accordance with this Paragraph.

Notwithstanding the foregoing, County may elect to provide notice to Contractor using electronic mail. If County elects to provide notice by such means, such notice shall be deemed given as of the date indicated on the electronic mail message. Contractor's electronic email address shall be: manaz@mapinc.com."

12. Agreement "EXHIBIT A, PHYSICIAN SERVICES FOR THE INDIGENT PROGRAM ("PSIP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments A-1 through A-14, shall be replaced with “EXHIBIT A-1, PHYSICIAN SERVICES FOR THE INDIGENT PROGRAM ("PSIP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments A-1 through A-12, attached hereto and incorporated herein as reference.

13. Agreement "EXHIBIT B, PUBLIC/PRIVATE CONTRACTORSHIP (PPP) PROGRAM CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments B-1 through B-9, shall be replaced with "EXHIBIT B-1, AMBULATORY CARE NETWORK, CLAIMS ADJUDICATION SERVICES, STATEMENT OF WORK", including Attachments B-1 through B-7, attached hereto and incorporated herein as reference.

14. Agreement "EXHIBIT C, PHYSICIAN SERVICES FOR THE METROCARE PHYSICIAN PROGRAM ("MPP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments C-1 through C-10, shall be replaced with “EXHIBIT C-1, METROCARE PHYSICIAN PROGRAM ("MPP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments C-1 through C-11, attached hereto and incorporated herein as reference.

15. Effective April 1, 2012, all Agreement references to "EXHIBIT A, PHYSICIAN SERVICES FOR THE INDIGENT PROGRAM ("PSIP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments A-1 through A-14, shall be understood to reference “EXHIBIT A-1, PHYSICIAN SERVICES FOR THE INDIGENT PROGRAM ("PSIP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments A-1 through A-12.

16. Effective April 1, 2012, all Agreement references to "EXHIBIT B, PUBLIC/PRIVATE CONTRACTORSHIP (PPP) PROGRAM CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments B-1 through B-9, shall be understood to reference "EXHIBIT B-1, AMBULATORY CARE NETWORK, CLAIMS ADJUDICATION SERVICES, STATEMENT OF WORK", including Attachments B-1 through B-7.

17. Effective April 1, 2012, all Agreement references to "EXHIBIT C, PHYSICIAN SERVICES FOR THE METROCARE PHYSICIAN PROGRAM ("MPP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments C-1 through C-10, shall be understood to reference "EXHIBIT **C-1**, METROCARE PHYSICIAN PROGRAM ("MPP") CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK", including Attachments C-1 through C-11.

18. Effective April 1, 2012, any references in the Agreement to "Public Private Partnership Program" or "PPP" shall be deemed references to "Community Partner Program" or "CP."

19. Except for the changes set forth hereinabove, Agreement shall not be changed in any other respect by this Amendment.

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by its Director of Health Services, and Contractor has caused this Amendment to be executed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By_____
Mitchell H. Katz, M.D.
Director

AMERICAN INSURANCE ADMINISTRATORS
("AIA"), A SUBSIDIARY OF MANAGEMENT
APPLIED PROGRAMMING, INC.
Contractor

By _____
Signature

_____
Printed Name

Title _____
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
John Krattli, Acting County Counsel

EXHIBIT A

PHYSICIAN SERVICES FOR THE INDIGENT PROGRAM (PSIP)
CLAIMS ADJUDICATION SERVICES
STATEMENT OF WORK

1. Definitions:

A. Claims Adjudication Services: Claims adjudication services for the PSIP Program include receipt, review, Medi-Cal/Medicare/Other insurance coverage identification, PSIP program eligibility determination, and provision of preliminary payment listings and final payment information in electronic formats for PSIP claims submitted by physicians for eligible medical services rendered to eligible indigent patients. These services shall be provided according to PSIP policies, procedures, and instructions, which are subject to revision from time to time. For purposes of this Agreement, a claim includes a Physician Services for Indigents Program (PSIP) Demographic Data Form, Attachment A-1, a Centers for Medicare and Medicaid Services (“CMS-1500) Form (formerly known as a Health Care Financing Administration “HCFA 1500” Form), Attachment A-2, and other forms that may be approved and required by the Director.

B. Adjudicated: As used herein, the term "adjudicated" shall apply to claims for which all claims

adjudication services have been completed, according to the PSIP policies and procedures, and a payment request or denial has been issued.

C. Denied: As used herein, the term "denied" shall mean a claim or medical procedure that has been adjudicated according to program policies and procedures and found not to be payable.

D. Electronic Claim: As used herein, the term "electronic claim" shall mean a claim that is submitted to the Contractor on a disk, or other form of computer media by PSIP physicians for reimbursement of eligible medical services rendered to eligible indigent patients.

E. Fiscal Year ("FY"): As used herein, the term "fiscal year" shall mean the twelve (12) month period beginning July 1st of a year and ending June 30th of the following year.

F. Hard-Copy Claim: As used herein, the term "hard-copy claim" shall mean a claim that is submitted to Contractor on paper (hard copy CMS 1500 Form and PSIP forms) by PSIP physicians for reimbursement of eligible medical services rendered to eligible indigent patients.

G. On-line Access: As used herein, the term "on-line access" shall mean the electronic linkage of

Contractor's computerized claims adjudication system to County personal computers (PCs) located at County specified sites (minimum of two (2)) which permit County access to the PSIP Physician Profile Database ("PPD") and PSIP Database.

H. Administrative Appeal: As used herein, the term "Administrative Appeal" shall mean an appeal which 1) involves an issue exclusively related to the PSIP policies and procedures; and 2) does not involve medical issues.

I. Medical Appeal: As used herein, the term "Medical Appeal" shall mean an appeal which involves a medical issue exclusively, and requires the expertise of an appropriate medical professional for appeal resolution.

J. Contractor’s System: As used herein, the term "Contractor’s System" shall mean any and all computer systems/resources used by Contractor to perform claims adjudication, reporting, etc.

2. Contractor Personnel:

A. Contractor shall designate a Project Manager to lead and coordinate Contractor's claims adjudication services hereunder.

B. Notwithstanding any representation by County regarding the participation of County personnel in any

phase of this project, Contractor assumes sole responsibility for the timely accomplishment of all activities described herein.

3. County Personnel: Chief, Fiscal Services, Department of Health Services, shall be designated as County Project Manager (CPM) for activities hereunder, unless otherwise determined by Director. County personnel will be made available to Contractor at the sole-discretion of CPM to provide necessary input and assistance in order to answer questions and provide necessary liaison activities between Contractor and County departments. The word "County" or "Director" shall be deemed to refer to the CPM.

4. Services to Be Provided: Services to be provided immediately upon Board of Supervisors approval include, but shall not be limited to:

A. Contractor shall process hard-copy and electronic claims using an on-line claims processing system and line-item and/or on-line adjudication.

B. Contractor's claims review and processing procedures must include, but shall not be limited to, the following:

1) Sorting claims.

2) Date stamping (i.e., Month/Date/Year) all claims upon receipt, at the time of the original submission and any subsequent resubmission(s).

3) Reviewing claims for completeness and accuracy based on the PSIP billing instructions provided by County.

4) Rejecting and returning claims which are incomplete or inaccurate and return to the submitting physician within twelve (12) working days of claim receipt, with a Director approved letter stating the claim deficiencies and the procedures for resubmission, or as otherwise agreed to by Director and Contractor.

5) Entering the claim type (i.e., contract trauma, non-contract emergency, pediatrics, or obstetrics), reason for rejection, claim receipt date, physician’s name and tax identification number ("ID#"), patient’s name, date of service, and service location on Contractor’s system.

6) Entering all claim information and all data elements (Attachments A-3 to A-8) into the system for all complete claims.

7) Flagging all incomplete, erroneous, and duplicate claims.

8) Reflecting line-item denials.

9) Validating procedure and diagnosis codes.

10) Denying claims covered by insurance.

11) Adjudicating non-trauma claims for a total of twenty (20) working days from the date of receipt.

12) Trauma Patient Summary Number File Format Matching Data Elements: Contractor shall identify and adjudicate eligible trauma claims within twenty (20) working days following the Trauma Patient Summary Number (TPS#) match, by comparing the PSIP trauma claims with the TPS# hospital patients data file that are provided to Contractor by County's Emergency Medical Services Agency (EMS).

Contractor shall be responsible to electronically match the following specified PSIP trauma claims data elements as provided by County:

- Computer Media: Electronic transmission from Lancet
- Encoding Format: Flat ASCII file
- Matching Data Elements:
  - TPS# (**12** digit alphanumeric code)
  - Hospital Code(4 digit code)
  - Patient Name
  - Payer Code (or description)

- Date of Service

Contractor recognizes that the County format may change from time to time as a result of changing requirements or needs. At County's option, Contractor shall include or delete County specified matching data elements.

13) Automatically/manually assigning a unique claim number.

14) Performing audits and quality assurance sampling.

15) Providing claims reporting.

16) Performing other claim edits, as may be required by Director, from time to time.

17) Accepting amounts from the Director to be paid for each claim type, fund, and organization code, and being able to suspend any unprocessed claims which are not to be paid in the current payment cycle, and include any suspended claims in the next payment cycle in the order of the date received .

18) Preparing Remittance Advices ("RA"), pursuant to Attachment A-9 "Sample Remittance Advice Specifications", for claims adjudicated for payment and those denied due to Medi-Cal/Medicare coverage,

including the applicable Medi-Cal/Medicare numbers, and electronically transmitting via email the RAs on a bi-weekly basis to County site.

19) Slowing or ceasing claims adjudication services, upon Director's request, in order not to exceed PSIP funding limits.

20) Providing an electronic warrant file to County's Auditor Controller, which will group the claims by funds, including an electronic copy of the warrant register, identifying the amounts from the following funds:

a) Physicians Services Account – BW7.

b) Measure B – BW9, and any other available funds.

21) Processing an updated copy of the electronic warrant file, including the issue date and warrant number provided by the County, on the same day if received by no later than 10:00 a.m., and by the next business day if not, using high speed, secure electronic media, as specified and agreed to by Director, to transmit and receive the electronic warrant files and add them to the RA before it is printed.

22) Providing physical and/or electronic mailing services, i.e, addressing, stuffing, sealing, scanning and attaching documents and mailing RAs, including the RAs for denied claims, to PSIP physicians (County will reimburse Contractor $0.015 per claim for handling fee and the additional postage costs associated with the physical mailing). On the same day of mailing, Contractor shall electronically transmit, via email, the RA report to DHS Fiscal Services.

23) Making all Official County Fee Schedule ("OCFS") modifications to its claims adjudication programs necessary to process and adjudicate all PSIP claims and comply with this Exhibit, the Attachments, and modifications thereto, at no additional cost to County.

24) Recouping funds or reducing a physician's future claim payments (e.g., if the claim has been erroneously paid or if the physician receives a payment from the patient or third-party payor, after the claim has been paid), as instructed by Director, via a Director approved letter with recoupment payments to be sent directly to County along with a

copy of the RA to County, or if the RA is not available, advising physicians to provide the following information along with the refund check:

- patient's name,
- AIA claim number,
- date of service,
- amount of patient's refund,
- physician's tax ID number, and
- physician's license number;
- adjusting the physician account balances accordingly when a refund is received and,
- at Director’s discretion, providing the Director or his designee(s) with access to Contractor’s system to either cancel claim in full or indicate partial refund adjustment.

C. Establish and maintain a unique PPD Database and PSIP Database for each fiscal year (FY).

1) The PPD shall incorporate all data elements described in Attachment A-10, Contract Physician Profile Record Layout. Contractor shall regularly update the PPD to ensure that physician information, as requested on the Physician Enrollment Form, is

readily available to Director. The PPD shall be based on Attachment A-4, Physician Enrollment Form and Attachment A-3, Conditions of Participation Agreement, which each participating physician submits upon entry into PSIP and updates each FY or more often as necessary. The Physician Enrollment Form shall serve as written notice from the physician that information may be entered into the Database.

2) The PSIP Database incorporates all data elements necessary for all PSIP related work, including, but not limited to, preparing reports and providing data as described within this Agreement and related Attachments.

D. Provide electronic data for storage in County information repository on a monthly basis according to County specifications, as specified in the following Attachments:

- A-11: AIA Data Statement of Work
- A-12: AIA Record Layout/Dictionary

E. Review, analyze, and research all Administrative Appeal issues and recommend County action based on PSIP policies and procedures. Contractor shall regularly attend scheduled meetings of the County's Physician Reimbursement

Advisory Committee ("PRAC"). Upon Director's approval, Contractor shall refer all Medical Appeals to the Physician Appeals Board. Contractor shall prepare appeal summaries and notifications to physicians of appeal disposition. Responses to claim appeals shall be issued by Contractor with a Director approved letter, stating the appeal disposition and an updated RA, if appropriate. All claim appeal response letters are to be approved by Director and mailed by Contractor.

F. Provide system connectivity to two (2) County specified work stations to be designated by County's Project Manager. Contractor shall also provide the capability for County's personal computers, linked to Contractor's system, to have inquiry and view capability of data and records. County can, at the election of the Director and not affecting Contractor's system and data security, request manipulation and modification of any and all data elements and/or data structures in the PSIP Database and PPD for data input/output and downloads as an ASCII, comma delimited, or Microsoft Excel or Access file, with the results and/or summary of such manipulation onto County's computers or a common storage device agreed by the County. If requested by Director, Contractor shall provide

three (3) days of formal training for County on-line users and assistance as necessary for each year during the term of the Agreement. Director shall select the two (2) persons for which training will be provided.

G. Develop, maintain, and provide detailed written instructions for physician submission of claims, including electronic, as approved by Director. As needed or requested by Director, Contractor shall have workshops for County staff, physicians, and physician billing groups to support claim submission, both electronic and manual.

H. Provide and manage a telephone hot line for physicians to inquire on the status of claims. Questions regarding the PSIP program or policy issues are to be referred to Director. Upon physician request, Contractor will send out the Director's approved billing instructions. The hot line must be staffed from 8:00 a.m. to 4:30 p.m., Pacific Standard Time, Monday through Friday, except County holidays. At a minimum, the hot line must have voice mail or other message capabilities to receive calls during non-operation hours. Except for holidays and weekends, calls must be returned within 24 hours. A log of all calls must be maintained and shall include, but shall not be limited to:

- physician's name,
- billing group name,
- caller's name,
- claim number,
- date and time of call,
- a brief summary of the purpose and disposition of the call, and
- name of person who took the call.

This log shall be made available to Director upon request at all reasonable times, for review and for photocopying.

I. Prepare written materials for review and approval by Director prior to distribution (addressing, stuffing, and sealing envelopes) to physicians and deliver same to Director.

J. Develop and maintain a Backup System consisting of an electronic copy of the PSIP Database, PPD, and all other related data on CD or on other County specified computer media off-site. The PSIP Database shall be backed up on a daily basis; the PPD shall be backed up regularly. In the event that Contractor's system becomes inoperative, Director and Contractor shall mutually agree on a

reasonable time frame to resume processing physician claims.

K. Provide Online Access to all active FY physician claims until year-end reconciliation has been completed and determined closed by County.

5. Additional Requirements: In performing the services hereinabove, Contractor shall:

A. Perform at all times in a professional and businesslike manner when assisting physicians and answering physician's questions.

B. Employ industry standards to ensure appropriate payments to physicians under the PSIP program.

C. Respect the confidential nature of all information with regard to physician patient records and PSIP financial records. Contractor acknowledges the confidentiality of all physician patient data and, therefore, shall obtain/extract only that information needed to meet claims processing and adjudication requirements. All such collected information shall become the property of County upon the termination of this Agreement, unless otherwise agreed to by Director.

D. Prepare all correspondence to physicians in a professional and businesslike manner; no correspondence may

be hand written and all correspondence to physicians must be approved by Director in writing prior to sending, unless otherwise directed by County's Project Manager.

6. Optional Services: The County may exercise its option to require the Contractor to perform specific optional services. County may require the Contractor to provide Medi-Cal/Medicare eligibility matching services, and/or the services of an Audit Nurse Specialist, who will work with County staff to ensure the medical codes listed on the claims are appropriate, no more than two 8-hour days per month. The nurse will be required to have knowledge of medical and financial coding.

7. Access to information: In order for Contractor to provide the services described in this Exhibit, Director shall provide Contractor necessary and pertinent PSIP information, including operational/administrative records, and statistics.

Contractor shall return all the material provided by Director, upon his/her request, including but not limited to, PSIP Database data files, PPD data files, physician patient records/data, PSIP financial records, all information incidental to contract administration, all completed work, all PSIP data, in the same condition and sequence in which received within thirty (30) calendar days from date of request.

8. Reports: Contractor shall provide financial, management, and ad-hoc reports, as requested by CPM. Contractor shall submit a weekly report listing all claims received in-house, and claims denied, rejected, Medi-Cal covered, and adjudicated by FY of service, as requested by CPM. Claim management reports shall be submitted to CPM and shall include, but not be limited to, the following:

- Monthly reports with amounts of various payment categories and a monthly report that reflects weekly claim activity;
- Claims submitted and paid by individual physicians;
- Summary Reports (type/payment/status of claim);
- Claims by month or services or payment;
- Claims by physician tax ID#;
- Claims by physician license number;
- Claims reporting by procedure, diagnosis, and physician specialty by tax ID# and license number;
- Statistics and special reporting;
- RA Reports; and
- Ad-hoc reports, such as top 100 surgical codes, top 100 procedure codes, reports by physician specialty, and reports by hospital code to be provided within five (5) working days of written request.

The monthly report shall include weekly claim activity and shall reflect the number of rejected, denied, denied due to Medi-Cal/Medicare coverage, and adjudicated claims, as well as number of claims received in-house but which have not been processed and/or adjudicated. As each month of claims processing services is completed, the monthly report describing that month's claim activity is to be submitted to Director within ten (10) working days of the end of that completed month. Contractor shall provide analysis and interpretation of reports, as needed.

Contractor shall prepare all the necessary reconciliation reports (monthly, quarterly, biannually, yearly, or as otherwise requested by Director) for each FY and make any and all necessary payment and/or refund adjustments. Contractor shall re-adjudicate PSIP claims (due to changes in reimbursement rates by a percentage to be determined), as may be deemed necessary by CPM, and County shall pay for re-adjudicating the claims. If at any time re-adjudication is necessary due to an error of the contractor, then no additional per-claim costs shall be charged or billed by Contractor.

Director and Contractor shall mutually work to ensure that County's records and Contractor's PSIP database are fully

reconciled. Each FY shall be fully and completely reconciled as determined by Director.

9. Records and Audits: Subject to the conditions and terms set forth in the body of Agreement, Contractor agrees to make all billing and eligibility records available upon request, during normal business hours, to Director and authorized State and federal representatives, for inspection, audit, and copying. Contractor may use CD or other media for purposes of maintaining hard copy claim files. Contractor shall provide to Director such material in County specified electronic data format and on specified computer media.

Such records shall be retained in accordance with the RECORDS AND AUDITS Paragraph of the ADDITIONAL PROVISIONS.

10. Quality Improvement: Contractor shall provide to Director a written description of the quality control and claim management procedures employed by Contractor to process and adjudicate PSIP claims.

Quality control and claim management procedures shall include, but are not limited to, appropriate claim edits to ensure payment accuracy, non-payment of out-of-County claims, eligibility validation, flagging of duplicate billings and overpayments which require Contractor to recoup funds or to

reduce a physician's future claim payments, and audit trails to substantiate all adjudicated claim payment authorizations.

Director may periodically sample Contractor's work and request Contractor to provide an audit of its internal claims processing/adjudication procedures in order to determine the accuracy of Contractor's claims processing/adjudication practices. Should any work be inaccurate, as determined by Director, Director will notify Contractor within a reasonable period of time of such findings. Contractor shall correct any and all inaccuracies within ten (10) working days of receipt of notice of any errors and such correction shall be at no additional cost to County. In the event that Director finds that the errors have not been corrected by Contractor, the cycle of corrective action by Contractor and re-sampling by Director may, at Director's sole discretion, be repeated. Director will notify Contractor within a reasonable period of time of the re-sampling results.

11. Payment: Contractor shall bill County in arrears. The sole compensation to Contractor for services provided hereunder shall be as follows:

A. Contract Trauma, Non-Contract Emergency, Pediatrics, or Obstetrics:

1) Set-up Fees: Contractor shall not receive a set-up fee.

2) Systems Modifications: Contractor shall receive a fee which shall not exceed $80 per programming hour or prorated portion thereof for periods less than one hour for revised or new programming requested by Director, the rate and process which the parties will use as described below:

a) Contractor shall submit to Director a quotation in writing for the projected work, including an estimated number of programmer hours for completion of the programming task.

b) Director shall determine the credibility of the estimate submitted by Contractor and, if necessary, revise the estimated number of hours requested for performing the programming task. Director shall apprise Contractor in writing of County's acceptance of the quotation or of the revised estimate within ten (10) calendar days of the Director's receipt of the quotation.

c) Contractor shall, upon completion of the work, submit an invoice to County with the

actual number of hours that was required to complete the programming Task, not to exceed, however, the number of hours for completion for the task as approved by Director in accordance with Subparagraph (2) above, and prepare and keep detailed records of staff work and time spent on any programming task hereunder, and shall make them available for audit and photocopying upon request by County representative pursuant to Paragraph 9 (Records and Audits) of this Exhibit.

3) Adjudication Fees: Contractor shall receive a fee of $3.15 for each manual (hard copy) claim and $1.65 for each electronic service claim adjudicated during a Fiscal Year resulting in payment to a PSIP Physician by the County.

B. Handling Fee and Postage for Mailing Services: County will reimburse Contractor $0.015 per claim for handling fee and the additional cost of postage associated with the physical mailing described in Paragraph 4, Services To Be Provided, Subparagraph B, 22 of this Exhibit.

C. Trauma Patient Summary (TPS) Number Matching: Contractor shall not receive a fee for TPS matching.

D. Printing Services: Contractor shall receive reimbursement for the costs of printing services (e.g. physician enrollment packages, PSIP newsletters, etc.)

E. Optional Services

1) Audit Nurse Specialist: Contractor shall receive a fee of $40 per hour or prorated portion thereof for periods less than one hour for the services provided by an Audit Nurse Specialist, as described in Paragraph 6, Optional Requirements.

2) Medi-Cal Eligibility Matching: Contractor shall receive a fee of $2,000 per month to perform Medi-Cal eligibility matching, as described in Paragraph 6, Optional Requirements.

3) Medicare Eligibility Matching: Contractor shall receive a fee of $1,500 per month to perform Medicare eligibility matching, as described in Paragraph 6, Optional Requirements.

4) Data Reporting: Contractor shall not receive a fee for Data Reporting, as described in Attachment A-3, Conditions of Participation Agreement.

5) Providing Data to County Information Repository: Contractor shall not receive a fee for providing data for storage in County Information

Repository, as per specifications described in Attachment A-12, AIA Record Layout.

F. Corrections: Corrections of any and all claims due to Contractor's errors, as determined by County, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. Should any work be inaccurate, as determined by County, Contractor shall promptly correct all inaccurate or unacceptable work to conform to the requirements of this Exhibit, in accordance with Paragraph 10, Quality Improvement, and the Attachments, or as otherwise determined by County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work is acceptable to County. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County.

G. Specified Time Period: County shall be liable to Contractor with regard to amounts payable to Contractor for services performed hereunder that fall within a fiscal year time period specified in the Agreement.

H. Invoices: Contractor shall submit a monthly invoice, in arrears, showing all claims processed and

adjudicated, the amount of Medi-Cal/Medicare/Other Insurance eligible claims, and the costs for mailing services for the previous month of service. County shall pay all invoices within thirty (30) calendar days from receipt of complete and correct billing, as determined by CPM. County shall only reimburse Contractor for each adjudicated claim that result in payment to PSIP Physician by Director or Denied Medi-Cal/Medicare/Other insurance eligible claim.

In the event that Director requires Contractor to re-adjudicate any and all claims due to the year-end reconciliation process, County shall pay only for the programming cost to calculate the adjusted payment amount for each claim. County shall not pay the negotiated processing and adjudication fee per claim.

I. Accuracy of Work: Corrections of any and all claims due to Contractor's errors, as determined by Director, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County. Contractor shall promptly correct all inaccurate or

unacceptable work to conform to the requirements of this Exhibit and Attachments at no additional cost to County. County may withhold fifteen percent (15%) of Contractor’s invoice amount until all claims processing services work is acceptable to County.

EXHIBIT B - 1

AMBULATORY CARE NETWORK
CLAIMS ADJUDICATION SERVICES
STATEMENT OF WORK

1. Definition:

A. Claims Adjudication Services: Claims adjudication services of Ambulatory Care Network (ACN) claims include receipt, review, and approval for reimbursement for each ACN claim submitted by Community Partners (CPs) for eligible primary care, specialty care, dental care, and any related pharmaceutical and/or ancillary services rendered to eligible indigent patients of ACN. These services shall be provided in accordance with ACN policies, guidelines, procedures, and/or instructions. For purposes of this Agreement, a claim includes Form CMS-1500 (Attachment B-1), Pharmacy Claim Form (30-10) (Attachment B-2), and other electronic forms as approved by County and issued to Contractor through Change Notice as described on paragraph 8 of the Agreement.

B. Adjudicated: As used herein, the term "adjudicated" shall mean the process by which the reimbursement rate is determined in accordance with ACN's policies, guidelines, procedures and/or instructions and Attachment B-3, Claims Adjudications/Reimbursements Guidelines.

C. Community Partner: As used herein, the term "Community Partner" shall mean those ACN contractors who are partners with the County in the delivery of health care services under the County's Healthy Way LA (HWLA)

Matched and Unmatched Programs and Clinic Capacity Expansion Project (CCEP).

D. Denied: As used herein, the term "denied" shall mean a claim or medical procedure that has been adjudicated by Contractor in accordance with ACN's policies, guidelines, procedures and/or instructions and found not to be payable by Contractor.

E. Director. As used herein, the term "Director" shall refer to County's Director of Health Services, or his/or her authorized designee(s).

F. Electronic Claim: As used herein, the term "electronic claim" shall mean a claim that is submitted to the Contractor electronically, by email or file transfer on a disk, or some other form of computer media. by a CP for reimbursement for outpatient medical services rendered by the CP to ACN eligible indigent patients.

G. Fiscal Year ("FY"): As used herein, the term "fiscal year" shall mean the twelve (12) month period beginning July 1st of a year and ending June 30th of the following year.

H. Hard Copy Claim: As used herein, the term "hard copy claim" shall mean a claim that is submitted to Contractor on paper, hard-copy Form CMS-1500 (Attachment B-1) or Pharmacy Claim Form 30-1 (Attachment B-2), by CPs for reimbursement for outpatient medical services rendered to eligible indigent patients.

I. On-line Access: As used herein, the term "on-line access" shall mean the electronic linkage of Contractor's system to County personal

computers ("PCs") located at County specified sites (minimum of two [2]) which permit County access to the CPs Database and ACN Database.

2. Contractor Personnel:

A. Contractor shall designate a Project Manager to lead and coordinate Contractor's claims processing services hereunder.

B. Notwithstanding any representation by County regarding the participation of County personnel in any phase of this project, Contractor assumes sole responsibility for the timely accomplishment of all activities described herein.

3. County Personnel:

A. Director. The Director of Ambulatory Care Network, or his/or her designee, shall be designated as the County Project Manager (CPM) for activities hereunder, unless otherwise determined by Director.

B. County Project Manager. County personnel will be made available to Contractor at the sole-discretion of CPM to provide necessary input and assistance in order to answer questions and provide necessary liaison activities between Contractor and County departments. The word "County" or "Director" shall be deemed to refer to the CPM.

4. Services To Be Provided: Services to be provided within thirty (30) calendar days of Board of Supervisors' approval include, but shall not be limited to:

A. Contractor shall process hard copy and electronic ACN claims for reimbursement of contract outpatient medical services (i.e., primary, specialty, dental, related pharmaceutical and/or ancillary services) using an on-line claims

processing system and line-item and/or on-line adjudication pursuant to ACN contract requirements.

B. Contractor's on-line claims review and processing procedures must include, but not be limited to, the following:

1) Sorting claims.

2) Date-stamping (i.e., Month/Date/Year) all claims upon receipt at the time of the original submission and at the time of any subsequent resubmission.

3) Reviewing claims for completeness and accuracy based on the billing instructions developed by County.

4) Rejecting claim if it is incomplete or submitted later than the submission deadline as directed by County and return to the submitting CP within twelve (12) working days of claim receipt date, with a Director approved form correspondence, stating the problem with the claim and the procedures for resubmission, or as otherwise agreed to by Director and Contractor. Enter the reason for rejection, claim receipt date, CP's name and tax ID number, patient's name, date of service, and service location on Contractor's system.

5) Entering all claim information and all specified data elements as requested on Form CMS-1500 (Attachment B-1), or Pharmacy Claim Form (30-10) (Attachment B-2), into the system for all complete claims for each submission deadline per billing instructions.

Contractor shall deliver one (1) set of the Remittance Advices (RAs) to Director for the files. Contractor shall provide mailing services, i.e., address, stuff, and seal envelopes, and mail the RAs, including the RAs for denied claims, to CPs. County shall reimburse Contractor $0.015 per claim and the postage costs associated with the mailing. For those CPs who have access to Contractor's File Transfer Protocol (FTP) site, Contractor will send an electronic notification to each CP to retrieve their respective RA files at no cost to County. Contractor shall send County an updated list of clinics that have access to their FTP site upon execution of this amendment and within ten (10) business days of any change to the list.

6) Matching Medi-Cal Eligible Database File and Data Matching Elements:

a. Contractor shall reconcile the patient information data for all claims against the most recent Medi-Cal eligible database file provided by County, if available, before processing the claims for payment and deny any claims that are Medi-Cal eligible. Contractor shall provide County and CPs with a RA indicating: 1) eligible Medi-Cal denied claims and Medi-Cal numbers; 2) other denied claims; 3) reason for denial; and 4) summary of denied claims by reason code.

b. Director shall have the discretion, on a periodic basis or upon the conclusion of each fiscal year, to request Contractor to

conduct a Medi-Cal reconciliation: in which contractor shall: i) reconcile some or all of the claims submitted by all CPs over the terms of their respective Agreements against a database containing the identities of all Medi-Cal eligible patients provided by County, if available, to determine if CP has been reimbursed for services provided to Medi-Cal "eligible" patients; ii) provide County and CPs within twelve (12) business days from County's request with the Retro Medi-Cal RA indicating the eligible Medi-Cal claims and Medi-Cal numbers; iii) provide County with Medi-Cal check register indicating the amount due to County; and iv) withhold such amount from CPs' subsequent RAs, if periodic or final Medi-Cal reconciliation process indicates that CP has been reimbursed for Medi-Cal eligible patients,.

c) Contractor shall match the data elements below against the database containing the identities of all Medi-Cal eligible patients:

- Name
- Date of Birth
- Gender
- Social Security Number (SSN), if provided
- Service date

d) Contactor shall provide an electronic data listing of Medi-Cal eligible patient information if requested by the Director.

7) Contractor shall provide Director a list of canceled claims before each RA and after Contractor has canceled the claims (e.g., if the claim has been erroneously paid or if the CP receives a payment from the patient or third-party payor, after the claim has been paid, or at County's request as a result of an audit).

Contractor shall withhold the canceled claim amounts from CP's subsequent RAs. Contractor shall also provide CP a list of their canceled claims for the period prior to processing the RA including the same data elements indicated on a RA.

8) Contractor shall reconcile all programs with the same service before each RA and cancel any duplicate claims for the same patient based on the claims submission date. Claims submitted with a later submission date for the same patient, same date of service shall be canceled. Contractor shall provide County and CP with a list of those cancelled claims.

9) Flag all incomplete, erroneous, or duplicate claims.

10) Reflect line-item denials.

11) Validate procedure and diagnosis codes.

12) Automatic/manual assignment of a unique claim number.

13) Audits and quality assurance sampling.

14) Claims reporting.

15) Other claim edits that may be required by Director from time to time.

16) Establish and maintain a separate and unique CP Database and ACN Database for each FY the Agreement is in effect.

a) The ACN Database incorporates all data elements necessary for all ACN related work, including, but not limited to, preparing reports, providing Ambulatory Care Network Reporting System ("ACNRS") data, and as otherwise described in this Exhibit and Attachments B-4, Claims Adjudication Services Reporting System; B-5, Claims Adjudication Data Record Layout; B-6, Data Code Table; and B-7, Provider Profile, or as agreed upon in writing by both parties.

b) The CPs Database shall incorporate all data elements described in this Exhibit and Attachments B-4 through B-7, or as agreed upon in writing by both parties. Contractor shall regularly update the CPs Database to ensure that CP information, as requested on the CP Information Form, is readily available. The CP Database may only be updated with a written notice from County.

c) Contractor shall provide Director with a copy of the ACN Database within ten (10) working days following the end of the month the Agreement is in effect or as otherwise agreed between parties in writing if changes are required to existing ACN Database prior to files transmission.

17) Provide system connectivity to a minimum of two (2) County specified work stations to be designated by Director. Contractor shall also provide the capability to access both the ACN Database and CP Database. Contractor shall provide the capability for County's personal computers, linked to Contractor's system, to have inquiry capability and to request manipulation of any and all data elements in the ACN Database and CP Database and download the results and/or summary of such manipulation as an ASCII file onto County's personal computers. If requested by County, Contractor shall provide three (3) days of formal training for County on-line users and assistance as necessary during the term of the Agreement. County shall provide Contractor with the names of the selected trainees.

County shall have the discretion to accept that Contractor performs the inquiry and manipulation of the data elements of ACN Database and CP Database in lieu of County's personnel, and enable County's personnel to download the summaries/results or the reports directly from Contractor's system, or submit job requests for an overnight email of the reports. Contractor shall provide the requested reports within fifteen (15) business days. County has the discretion to, on a case by case basis, approve written requests from Contractor for extension of this timeframe. Such approval shall be provided to Contractor in writing.

18) Develop, maintain, and provide detailed written instructions for CPs regarding the submission of electronic claims, as approved by

Director. Contractor shall have workshops for County, CPs, to include County's and CP's billing and/or finance staff, to support electronic claim submission, as needed or requested by Director.

19) Establish and maintain a telephone hot line for CPs to inquire on the status of claims (Questions regarding the ACN policy and procedures shall be directed to Director. Upon request, Contractor shall provide a copy of the Director's approved billing instructions). The hot line must be staffed from 8:00 a.m. to 4:30 p.m. Pacific Standard Time, Monday through Friday, except County holidays. The County's current official holidays are: New Year's Day, Martin L. King, Jr. Day, President's Day, Memorial Day, Fourth of July, Labor Day, Columbus Day, Veteran's Day, Thanksgiving Day and the day after, and Christmas Day.

At a minimum, the hot line shall have voice mail or other message capabilities to receive calls during non-operation hours. Except for holidays and weekends, calls shall be returned within 24 hours. A log of all calls must be maintained and shall include, but not limited to, the CP's name, billing group name, caller's name, claim number, date and time of call, a brief summary of the purpose and disposition of the call, and name of person who took the call (Log shall be made available to Director upon request at all reasonable times, for review and for photocopying).

20) Prepare written materials for review and approval by Director prior to distribution (address, stuff, and seal envelopes) and mail Director approved materials to CPs and deliver same to Director.

21) Develop and maintain a Backup System consisting of an electronic copy of the ACN Database, CPs Database, and all other related data on CD or on other County specified computer media off-site. The ACN Database shall be backed up on a daily basis; the CPs Database shall be backed up whenever a change occurs, including an addition or deletion of fields, a CP address change, etc. In the event that Contractor's system becomes inoperative, Contractor shall notify Director immediately in writing and by phone of systems initial downtime. Director and Contractor shall mutually agree on a reasonable time frame to resume processing CPs claims.

C. Provide ACN Data Reporting according to County specifications, as specified in Attachments B-4 to B-7 or as subsequently modified and agreed upon in writing by both parties.

5. Additional Requirements: In performing the services hereinabove, Contractor shall:

A. Perform at all times in a professional and businesslike manner when assisting ACN CP(s) and answering CP(s)' questions.

B. Employ industry standards to ensure appropriate payments to CP(s) under the ACN.

C. Ensure the confidentiality of all information with regard to CP(s) patient records and ACN financial records. Contractor acknowledges the confidentiality of all CP(s) patient data and, therefore, shall obtain/extract only that information needed to meet claims processing and adjudication

requirements. All such collected information shall become the property of County upon the termination of this Agreement.

D. Prepare all electronic and/or written correspondence to CP(s) in a professional and businesslike manner; no correspondence shall be hand written. All correspondence related to policy and procedures to CP(s) must be submitted to the Director for review and approval within ten (10) business days prior to sending.

6. Access to information: County shall provide Contractor the necessary and pertinent CP information, including operational and administrative records to provide services hereunder.

Contractor shall return all the material provided by County, within thirty (30) days of County's request, including but not limited to, ACN Database data files, CPs Database files, CPs patient records/data, ACN financial records, all information incidental to contract administration, all completed work, and all ACN data.

7. Reports: Contractor shall provide financial and management reports as requested by County within ten (10) business days. If a modification to existing management reports is needed. The timeframe needed to complete the modification shall be agreed upon by both parties in writing. Contractor shall provide ad hoc reports within the timeframe as request by County unless otherwise agreed by both parties in writing. Claim Management reports shall be submitted as specified below and in an electronic format as requested by County and shall include, but not limited to, the following:

1. Summary visits reports by clinic (to be submitted bi-monthly, report with amounts of various payment categories);

2. Check Register (to be submitted bi-monthly summary, report(s) regarding payment/status of claim);

3. Year-To-Date Summary Visits Reports by clinic (to be submitted bi-monthly, report with amounts of various payment categories);

4. Year-To-Date Summary Check Register (to be submitted bi-monthly, summary reports regarding payment/status of claim);

5. Duplicate Claims Report (to be submitted by-monthly);

6. RA Reports (to be submitted bi-monthly);

7. Reconciliation reports, i.e. Matched Pending Claims (to be submitted on the first and third week of each month);

8. Target Visits Report (to be submitted annually)

9. Summary of Estimated/Actual Visit Reports (to be submitted monthly)

10. Year-To-Date Estimated/Actual Visit/Expenditure Reports (to be submitted monthly)

11. Year-To-Date Consolidate Programs Reports (to be submitted monthly)

12. Year-To-Date Estimated Budget Report (to be submitted monthly)

13. P89 and P95 (to be submitted monthly reports to include the number of claims and amount paid by month of service); and

As each month of claims processing services is completed, the monthly reports describing that month's claim activity shall be submitted to County within ten (10) working days following the end of that completed month. Contractor shall provide analysis and interpretation of reports, as needed.

Contractor shall prepare all the necessary reconciliation reports (monthly, quarterly, biannually, yearly, or as otherwise requested by County) for each FY and make any and all necessary adjustments to ACN Database. Contractor shall re-adjudicate CP's claims, as may be deemed necessary by Director, at no additional per-claim cost to County when it has been determined that the Contractor made an error. If County has made an error and the CP's claim requires re-adjudicating, County shall be charged for re-adjudicating the claim. Director and Contractor shall mutually work to ensure that County's records and Contractor's ACN Database are reconciled. Each FY shall be reconciled as determined by Director.

8. Records and Audits: Subject to the conditions and terms set forth in the body of Agreement, Contractor agrees to make all billing and eligibility records available upon request, during normal business hours, to County and authorized State and federal representatives, for purposes of inspection, audit, and copying. Contractor may use microfilm or other media for purposes of maintaining hard copy claim files. Contractor shall provide to Director such material in County specified electronic data format and on specified computer media.

9. Quality Improvement: Contractor shall provide to Director a written description of the quality control and claim management procedures employed by Contractor to process and adjudicate ACN claims.

Quality control and claim management procedures shall include, but are not limited to, appropriate claim edits to ensure record accuracy (e.g., eligibility validation, flagging of duplicate billings), and audit trails to substantiate all adjudicated claim payment authorizations.

Director may periodically sample Contractor's work and request Contractor to provide an audit of its internal claims processing/adjudication procedures in order to determine the accuracy of Contractor's claims processing/adjudication practices. Should any work be inaccurate, as determined by Director, Director will notify Contractor within a reasonable period of time of such findings. Contractor shall correct any and all inaccuracies within ten (10) working days of receipt of notice of any errors and such correction shall be at no additional cost to County. In the event that Director finds that the errors have not been corrected by Contractor, the cycle of corrective action by Contractor and re-sampling by Director may, at Director's sole discretion, be repeated. Director will notify Contractor within a reasonable period of time of the re-sampling results.

10. Payment: The sole compensation to Contractor for services provided hereunder shall be as follows:

A. For Primary Care Medical Services:

1) Initial Set up Fees: Contractor shall not receive a set-up fee.

2) Adjudication Fees:

a) For each adjudicated hard copy primary care service claim or ancillary claim associated with a primary care service that either results in a denial or payment to a CP(s), Contractor shall receive a fee of $2.35.

b) For each adjudicated electronic primary care service claim or ancillary claim associated with a primary care service that results in a denial or payment to a CP(s), Contractor shall be

reimbursed based on the aggregate volume of primary care services claims submitted for each fiscal year that primary care services and associated ancillary services were provided, regardless of when the claim(s) is adjudicated. The fee schedule for the overall volume of primary care and associated ancillary services is as follows:

i) Up to 500,000 claims $1.35 per claim

ii) 500,001 to 750,000 claims $1.10 per claim

iii) 750,001 to one million claims $1.00 per claim

iv) over one million claims $0.90 per claim

c) For each related hard copy pharmaceutical claim adjudicated resulting in a denial or payment to a CP(s), Contractor shall receive a fee of $1.00.

d) For each electronic pharmaceutical claim adjudicated resulting in a denial or payment to a CP(s), Contractor shall receive a fee of $0.85 per claim.

B. For Specialty and Dental Care Services:

1) Initial Set up Fees: Contractor shall not receive a set-up fee.

2) Adjudication Fees:

a) For each adjudicated hard copy specialty or dental service claim or ancillary claim associated with an adjudicated specialty care service claim, that either results in a denial or

payment to a CP(s), Contractor shall receive a fee of $2.60 per claim.

b) For each electronic specialty or dental service claim or ancillary claim associated with a specialty care service adjudicated resulting in a denial or payment to a CP(s), Contractor shall receive a fee of $1.85 per claim.

c) For each related hard copy pharmaceutical claim adjudicated resulting in a denial or payment to a CP(s), Contractor shall receive a fee of $1.00.

d) For each related electronic pharmaceutical claim adjudicated resulting in a denial or payment to a CP(s), Contractor shall receive a fee of $0.85 per claim.

C. Mailing Services: Contractor shall receive a fee of $0.015 per claim and the actual cost of postage associated with the mailing described in Paragraph 4, Services To Be Provided, Subparagraph B, 5, of this Exhibit.

D. Ambulatory Care Network Reporting System (ACNRS) Reporting: Contractor shall not receive reimbursement for reporting.

E. Systems Modifications: Contractor shall receive a fee, not to exceed, Eighty Dollars ($80) per programming hour or a prorated portion thereof for periods less than one hour for revised or new programming requested by County. The process which the parties shall use is as follows:

1) Contractor shall submit to Director a written quotation for the projected work to include a description of the necessary programming

tasks, including the estimated number of hours and staff level for completion of the described task.

2) County shall review quote and determine if the hours submitted by Contractor are acceptable. If not, County will revise the estimated number of hours requested for performing the programming task. County Director shall apprise Contractor in writing of Director's acceptance of the quotation or of the revised estimate within ten (10) calendar days of the Director's receipt of the quotation.

3) Upon completion of the work, Contractor shall submit an invoice to County with the actual number of hours per each staff level that was required to complete the programming task, not to exceed the number of hours and staff level as approved by County. Contractor shall keep detailed records of staff work and time spent on any programming task hereunder, and shall make them available for audit and photocopying upon request by Director.

F. File Fix Fee: If claims were processed in error through no fault of Contractor, County will pay Contractor File Fix Fee as follows:

1) Within the same policy/program: if a CP's claims are submitted to and adjudicated under the wrong clinic's Tax ID and/or suffix within the same policy/program, Contractor shall receive a fee of Seven Hundred Fifty Dollars ($750) per Tax ID and/or suffix regardless of number of claims to be moved per Tax ID and/or suffix. Contractor shall modify the record by moving the claims to the appropriate clinic's Tax ID and/or

Suffix and adjust CP per clinic's allocation. Re-adjudication of claims is not required. For such a file fix, County shall instruct CP to submit claims information as per approved and standardized practice.

2) Within different policies/programs: If CP's claims are submitted to and adjudicated under the wrong policy/program, Contractor shall receive a fee of Four Hundred Dollars ($400) per clinic's Tax ID and/or Suffix to cancel the claims and adjust the CP per clinic's allocation. If cumulative number of claims to be cancelled is twenty (20) or less within each CP's organization regardless of the number of clinic's Tax ID and/or Suffix, Contractor shall not receive a file fix fee. For such cancellation, County shall instruct CP to submit claims information as per approved and standardized practice.

G. Invoices: Contractor shall submit an invoice monthly in arrears, reflecting all claims processed and adjudicated claims and the costs for mailing services for the previous month of service. County shall only pay for claims that have completed the adjudication process, i.e., an RA has been issued. County shall reimburse Contractor for each adjudicated claim. County shall pay all invoices within thirty (30) calendar days from receipt of complete and correct billing, as determined by County.

In the event that Director requires Contractor to re-adjudicate any and all claims due to Contractor's error(s), no additional per claim cost shall be due Contractor for those claims affected by such error(s).

H. Accuracy of Work: Corrections of any and all claims due to Contractor's errors, as determined by County, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. The CPM will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County. Contractor shall promptly correct all inaccurate or unacceptable work to conform to the requirements of this Exhibit and Attachments at no additional cost to County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work for that billing cycle is acceptable to County.

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

WHCFA-1500CS-90 (2/04)

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)

FORM OWCP-1500 FORM RRB-1500

pcf30-1 comp
2

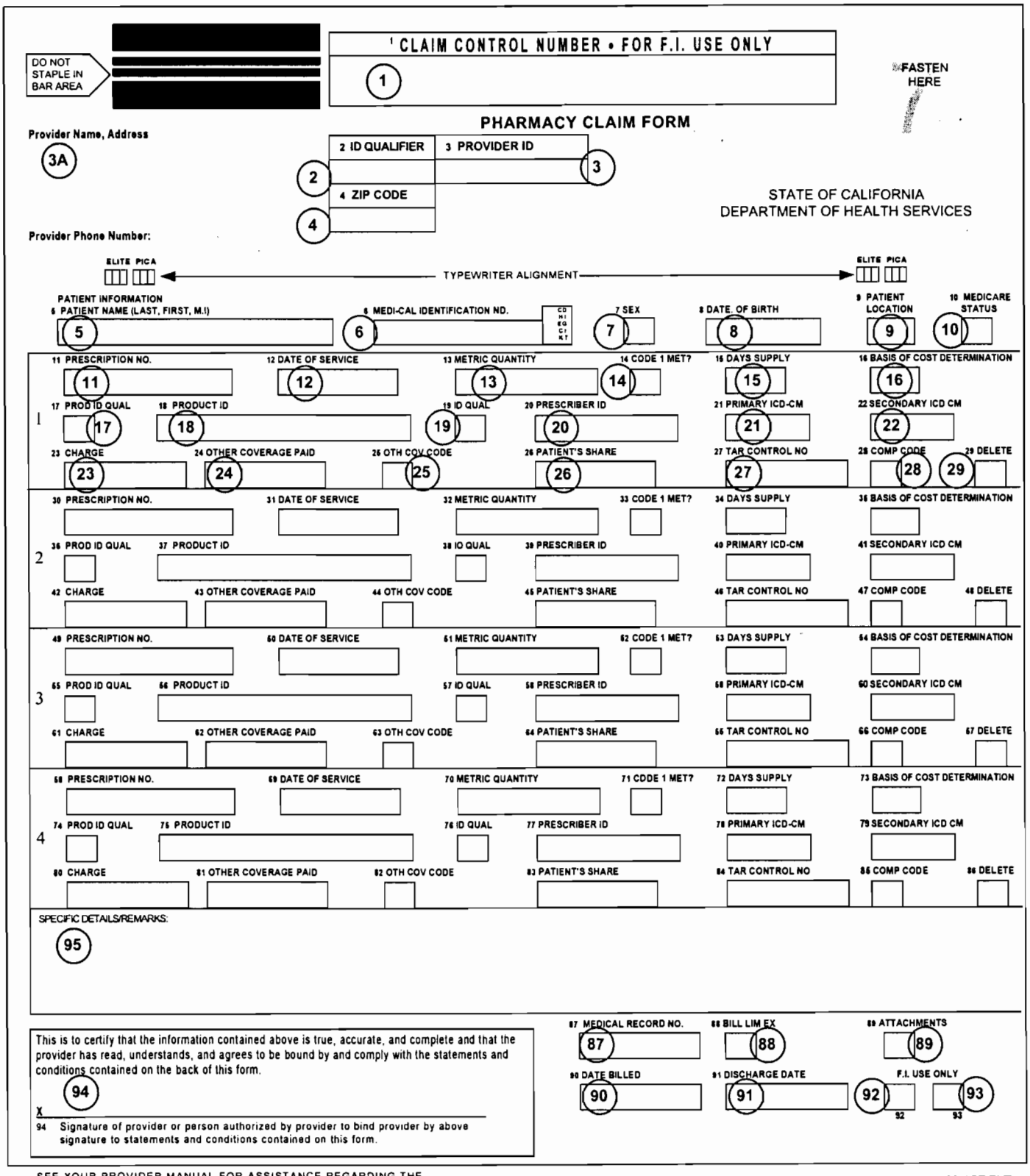

Figure 1. Medi-Cal Required Fields (Sample *Pharmacy Claim Form* [30-1])

ATTACHMENT B-3

CLAIMS ADJUDICATION AND REIMBURSMENT GUIDELINES

1. CLAIMS PROCESSING

A. Contractor shall conduct a monthly reconciliation process within the Healthy Way LA (HWLA) Health Care Initiative's primary and specialty care claims to ensure that only one (1) visit per patient per day was reimbursed regardless of the number of visits provided for each service. Contractor shall process the claim that was submitted first and cancel the claims submitted thereafter for the same visit date. Contractor shall withhold the canceled claims amounts from CP's subsequent RAs. Contractor shall provide Director a comprehensive list of canceled claims and CP a list of their canceled claims for the period including the same data elements indicated on a RA.

B. County shall provide Contractor with "Excluded Services" List for primary care services and any subsequent revisions prior to the implementation of claims processing for that list.

C. County shall provide Contractor with scope of specialty care services and scope of dental care service codes and rates, and any subsequent revisions prior to the implementation of claims processing for that service.

D. County shall provide Contractor with HWLA eligible patients' accumulative file bi-monthly including the patient's designated medical home.

E. Contractor shall process HWLA Matched claims for only those patients listed in the HWLA eligible patient file. Claims processed under the Matched Program for patient not listed on the eligible patients file shall be processed as Matched Pending

claims.

F. Contractor shall process Matched primary care claims based on HWLA eligible patient's designated medical home within the CP's organization clinic sites unless otherwise instructed by County in writing.

G. County shall provide Contractor with HWLA disenrollment and/or ineligible patients' accumulative file.

H. Contractor shall conduct a monthly reconciliation to all HWLA Matched paid claims from the beginning of the FY against the HWLA disenrollment and/or ineligible patient's file and cancel or convert the claim from the HWLA Matched Program to the HWLA Unmatched Program as instructed by County. Contractor shall withhold the canceled claim amounts from CP's subsequent RAs or adjust CP's allocation and record after claims conversion for each program. Contractor shall provide Director a comprehensive list of canceled or converted claims and CP a list of their canceled or converted claims for the period including the same data elements indicated on a RA.

I. County shall not reimburse Contractor a claims processing fee for any reconciliation process.

J. County shall provide Contractor list of CP clinic sites designation (per Tax ID) and the applicable payment rate for the HWLA Matched Program.

K. County shall provide Contractor with changes in CPs clinic designation or per visit reimbursement rate for the HWLA Matched Program.

L. For the HWLA Matched Program, Contractor shall reconcile change notice in clinic designation and/or per visit reimbursement rate with current information on file, and either pay or recoup the applicable difference in rate as of the effective date of the

change.

M. County shall provide Contractor a list of clinic sites (per Tax ID) that will be reimbursed for ancillary claims (pharmaceutical, laboratory, and radiology) associated with the HWLA Primary Care Matched Program. Contractor shall not process such claims for clinics not included in the list.

N. County shall provide Contractor with the Department of Health Services (DHS) Formularies for all approved pharmaceuticals for the applicable Programs/services and provide quarterly updates for such formularies. County shall identify on each DHS Formulary if a pre-authorization is required for a specific drug prior to reimbursement.

O. County shall provide Contractor list of National Drug Codes (NDC) for all pharmaceuticals listed on the DHS Formularies and reimbursement rate per quantity.

P. County shall provide Contractor with an Authorization Number file list containing pre-authorization numbers assigned for the entire fiscal year. Contractor shall match the authorization number shown on the claim with the Authorization Number file provided by County. For those claims where a match is identified, Contractor shall process the line item for that drug. If there is no match, Contractor shall deny the line item for that drug.

2. <u>CLAIMS REIMBURSEMENT RATE:</u>

A. Clinic Capacity Expansion Project (CCEP)

1. Contractor shall process claims at an all-inclusive rate of Ninety-four ($94) Dollars per visit for primary care services.
2. Contractor shall process claims at the lessor of actual cost or the

applicable Medi-Cal rate for the scope of specialty services provided by County and its associated ancillary services including pharmaceuticals.

B. Healthy Way LA Unmatched Program

1. Contractor shall process claims at an all-inclusive rate of Ninety-four ($94) Dollars per visit for primary care services.

2. Contractor shall process claims at the lessor of actual cost or the applicable Medi-Cal rate for the scope of specialty care services provided by County and its associated ancillary services.

3. Contractor shall process dental services claims for only those dental codes and at the rate as provided by County following Denti-Cal Guidelines.

4. Contractor shall process pharmaceutical claims associated with specialty and/or dental care services at the rate provided by County for only those drugs listed in DHS's applicable Formulary or for those pharmaceuticals that are listed beyond the DHS Formulary and have received pre-authorization by County.

C. Healthy Way LA Matched Program:

1. Contractor shall process primary care claim and/or on-site specialty care claim at the applicable per clinic visit rate provided by County.

2. Contractor shall process ancillary claims (laboratory and radiology) associated to primary care visit at the lessor of actual cost

or the applicable Medi-Cal rate. Contractor shall deny ancillary claims not associated to primary care visit.

3. Contractor shall process off-site specialty care claim and/or its associated ancillary services claims at the applicable Medicare rate. Contractor shall deny ancillary claims not associated to a specialty care visit.

4. Contractor shall process pharmaceutical claims associated with primary and/or specialty care services as applicable at the rate provided by County for only those drugs listed in DHS's applicable Formulary or for those pharmaceuticals that are listed beyond the DHS Formulary and have received pre-authorization by County.

5. Contractor shall process Matched Pending claims at the rate of $94 per visit from the funds designated as Matched Program funds.

6. Contractor shall process ancillary claims associated with visits for primary care Matched Pending claims at the lessor of actual cost or the applicable Medi-Cal rate. Contractor shall deny ancillary claims not associated to primary care visit.

7. Contractor shall process ancillary claims associated with visits for specialty care Matched Pending claims at the applicable Medicare rate. Contractor shall deny ancillary claims not associated to specialty care visit.

8. Contractor shall process a Matched Pending Reconciliation

RA twice a month or as otherwise instructed to reconcile all Matched Pending patient visit claims in its system with the most HWLA eligibility file provided by County. If match found, Contractor shall issue and RA for the difference of the $94 claim paid and the applicable rate per clinic per service and shall reconcile associated pharmacy and ancillary services claims for primary care and specialty care services.

ATTACHMENT B-4

CLAIMS ADJUDICATION SERVICES REPORTING SYSTEM

I. GENERAL RESPONSIBILITIES

CONTRACTOR shall fully perform, complete and deliver on time all work, deliverables and/or other items, however denoted, as set forth below and in documents attached and referenced herein, in full compliance with the requirements of this Attachment B-4, Claim Adjudication Services Reporting System.

The general responsibilities of CONTRACTOR under this Agreement shall include, but not be limited to, all labor required to establish data base(s) in order to meet State Department of Health Services ("STATE") and County of Los Angeles ("COUNTY") Ambulatory Care Network ("ACN") reporting requirements, produce STATE required data and submit to COUNTY, as described herein and in Attachment B-5 (Data Record Layout), and Attachment B-6 (Data Code Table).

CONTRACTOR will also provide test data to ensure that the record layout and format are consistent with program requirements. The test data are due thirty (30) calendar days after adjudication of the first forty (40) ACN claims.

II. OVERVIEW

This Attachment B-4, Claims Adjudication Services Reporting System, describes the services required of CONTRACTOR to provide data elements from ACN reimbursement claims to the COUNTY in order to meet STATE reporting requirements, comply with Low Income Health Program and other 1115 Medicaid Waiver requirements and any other initiatives as they implemented. The following are procedures for the timely submission of data to COUNTY.

III. PROJECT MANAGEMENT

The County of Los Angeles Department of Health Services (DHS) Project Manager shall administer the contract and ensure that CONTRACTOR meets or exceeds the contract requirements. The project coordination between CONTRACTOR and COUNTY shall be through the COUNTY's Project Manager, unless otherwise designated by Director.

IV. DATA REQUIREMENTS AND SUBMISSION PROCEDURES

A. DATA REQUIREMENTS

CONTRACTOR shall prepare ACN data in the required format, and informational/data requests on an ad-hoc basis. CONTRACTOR shall provide a CD copy of the ACN Community Partners Database as described herein and in

Attachment B-7 (Provider Profile).

- ACN Data Requirements

CONTRACTOR will be responsible to collect and maintain current information on ACN providers as well as provide the patient utilization information as described in Attachment B-5 (Data Record Layout) and Attachment B-6 (Data Code Table).

B. DATA SUBMISSION PROCEDURES

- ACN Data Submission Procedures

CONTRACTOR shall prepare and submit via mail ACN data to the Department of Health Services, Health Services Administration, Attention: --------Unit.

CONTRACTOR shall format the data according to the record lay-out requirements described herein and submit the data in a fixed block, ASCII format. The data will be submitted on computer media CD or via email. CONTRACTOR shall recognize that COUNTY data format requirements may change from time to time as a result of STATE program requirements or COUNTY information requirements, and CONTRACTOR must be able to adjust accordingly.

CONTRACTOR is responsible to ensure that the data are correctly identified, appropriately labeled, and loaded on CD.

COUNTY shall inspect and review ACN data provided by CONTRACTOR and reject all improperly formatted or unreadable data within ten (10) work days after receipt thereof. CONTRACTOR shall correct such data without additional cost to COUNTY.

V. REIMBURSEMENT

CONTRACTOR shall not be reimbursed by COUNTY for services not described herein.

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(1) PATIENT LAST NAME	1	20	20	LEFT/ALPHANUMERIC	YES	NO	The full surname or family name of the patient.
(2) PATIENT FIRST NAME	21	35	15	LEFT/ALPHANUMERIC	YES	NO	The full first or given name of the patient, minimally the first name initial.
(3) PATIENT MIDDLE NAME	36	50	15	LEFT/ALPHANUMERIC	YES	YES	The full middle name of the patient when it is available. Minimally, the middle name initial.
(4) DATE OF BIRTH	51	58	8	DATE	YES	NO	The month, day, century and year of a person's birth. Used to calculate age at the time of an event.
(5) SEX	59	59	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate gender.
(6) RACE/ETHNICITY	60	60	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate race or ethnicity.
(7) PATIENT MARITAL STATUS	61	61	1	LEFT/ALPHANUMERIC	NO	YES	
(8) PRIMARY LANGUAGE CODE	62	63	2	LEFT/ALPHANUMERIC	YES	NO	
(9) PERMANENT FILE NUMBER (MRUN)	64	72	9	LEFT/ALPHANUMERIC	NO	YES	Permanent file # assigned by each facility to a patient record.
(10) PATIENT ACCOUNT NUMBER	73	86	14	LEFT/ALPHANUMERIC	YES	NO	Patient account number is generated and assigned by an individual CP program contractor for each submitted claim. It is the internal medical record number of an identified CP program provider.
(11) MOTHER MAIDEN NAME	87	106	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the mother of the patient.
(12) MOTHER FIRST NAME	107	121	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the mother of the patient.
(13) FATHER LAST NAME	122	141	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the father of the patient.
(14) FATHER FIRST NAME	142	156	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the father of the patient.
(15) SOCIAL SECURITY NUMBER	157	166	10	LEFT/ALPHANUMERIC	YES	NO	The patient's social security number.
(16) MEDI - CAL IDENTIFICATION NUMBER	167	181	15	LEFT/ALPHANUMERIC	YES	YES	The Medi-Cal identifier issued by the State of California to the patient receiving medical services.

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(17) PATIENT ADDRESS	182	216	35	LEFT/ALPHANUMERIC	YES	NO	The street number and street name, including street direction and apt. designation, of usual or permanent address.
(18) PATIENT CITY	217	236	20	LEFT/ALPHANUMERIC	YES	NO	The name of the city or town where the patient resides.
(19) PATIENT STATE	237	238	2	LEFT/ALPHANUMERIC	YES	NO	The name of the state where the patient resides.
(20) PATIENT ZIP	239	243	5	LEFT/ALPHANUMERIC	YES	NO	Zip code of patient's usual or permanent address.
(21) PATIENT BIRTH PLACE	244	263	20	LEFT/ALPHANUMERIC	NO	YES	The name of city, town, village, state, and/or country the patient was born.
(22) FAMILY SIZE	264	265	2	RIGHT/NUMERIC	NO	YES	Based on ATP faimily size definition.
(23) MONTHLY INCOME	266	272	7	RIGHT/NUMERIC	NO	YES	The total monthly income received for the previous month by all related family members residing with patient(s).
(24) SOURCE OF INCOME	273	273	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the primary or largest single source of family income.
(25) TYPE OF EMPLOYMENT	274	274	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the occupation of the patient's family primary wage earner.
(26) SERVICE SETTING CODE	275	276	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate a provider service setting.
(27) SERVICE UNITS CODE	277	278	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate the type of unit of medical service.
(28) SERVICE UNITS QUANTITY	279	282	4	LEFT/ALPHANUMERIC	YES	YES	The number of units of service provided during an incident of medical service.
(29) EMERGENCY ROOM PRIORITY FLAG	283	283	1	LEFT/ALPHANUMERIC	NO	YES	A flag indicating that an immediate action or remedy is required. This distinguishes emergency and non-emergency.
(30) DISCHARGE DISPOSITION CODE	284	285	2	LEFT/ALPHANUMERIC	YES	YES	
(31) DISCHARGE DATE	286	293	8	DATE	YES	YES	
(32) TYPE OF INPATIENT ADMISSION CODE	294	295	2	LEFT/ALPHANUMERIC	YES	YES	
(33) ADMIT DATE	296	303	8	DATE	YES	NO	

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(34) DATE OF INITIAL CLINIC VISIT	304	311	8	DATE	NO	YES	
(35) TYPE OF OUTPATIENT SERVICE	312	313	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate different outpatient service category by the care rendered or the specialty of the provider (e.g., clinic code, medical service, etc.)
(36) CLINIC CODE	314	318	5	LEFT/ALPHANUMERIC	NO	YES	The code which specifies hospital outpatient clinic or comprehensive health clinic or community (free-standing) clinic providing services (applicable to sub-projects).
(37) ENCOUNTER CHARGE CODE	319	328	10	LEFT/ALPHANUMERIC	NO	YES	
(38) TRAUMA PATIENT SEQUENCE NUMBER	329	336	8	LEFT/ALPHANUMERIC	NO	YES	This field is an eight (8) digit code assigned to trauma patients treated at designated trauma hospitals.
(39) ENCOUNTER PATIENT SERVICE CODE	337	343	7	LEFT/ALPHANUMERIC	NO	YES	
(40) NURSING UNIT	344	349	6	LEFT/ALPHANUMERIC	NO	YES	
(41) REMITTANCE ADVICE DATE	350	357	8	DATE	YES	YES	
(42) CURRENT CONDITION CODE	358	358	1	LEFT/ALPHANUMERIC	NO	YES	
(43) FAMILY PLANNING INDICATOR	359	359	1	LEFT/ALPHANUMERIC	NO	YES	
(44) ANCILLARY FLAG	360	360	1	LEFT/ALPHANUMERIC	YES	YES	
(45) EPSDT INDICATOR	361	361	1	LEFT/ALPHANUMERIC	NO	YES	
(46) SERVICE EVENT CHARGE AMOUNT	362	370	9	RIGHT/NUMERIC	YES	YES	The amount charged to a patient for medical services delivered during a service event.
(47) AMOUNT PAID	371	379	9	RIGHT/NUMERIC	YES	YES	The total dollars expended for defined units of service rendered to county patients (OP visits, IP days, ancillaries)

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(48) CLAIM NUMBER	380	394	15	LEFT/ALPHANUMERIC	YES	NO	Claim number is generated and assigned by AIA for each claim submitted. The claim number sequence is patient specific. A patient can potentially have 9,999 claims submitted per fiscal year.
(49) CARRIER CODE/PRIMARY	395	397	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by different facilities. (Three occurences: Primary carrier code, and two others: Secondary carrier code and tertiary carrier code)
(50) CARRIER CODE/SECONDARY	398	400	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by facility.
(51) CARRIER CODE/TERTIARY	401	403	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by facility.
(52) TOTAL ALLOWABLE AMOUNT	404	412	9	LEFT/ALPHANUMERIC	NO	YES	
(53) GENERAL RELIEF ID NUMBER	413	426	14	LEFT/ALPHANUMERIC	YES	YES	
(54) HOMELESS CODE	427	428	2	LEFT/ALPHANUMERIC	YES	NO	A code used to define a patient's living arrangement and/or status at the time of a submitted claim to an agency in the CP program.
(55) FUND CODE	429	429	1	LEFT/ALPHANUMERIC	YES	NO	A code used to define the program a patient is enrolled in and monies processed from such as Primary, HWLAP, SB474 (SPA6), HWLAS, Specialty, CCEP, and CCES.
(56) FILLER	430	430	1	N/A	NO	YES	
(57) FACILITY ID	431	439	9	LEFT/ALPHANUMERIC	YES	NO	
(58) FACILITY ID SUFFIX	440	441	2	LEFT/ALPHANUMERIC	YES	NO	
(59) SOURCE OF ADMISSION	442	443	2	LEFT/ALPHANUMERIC	NO	YES	

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(60) RECORD SOURCE	444	445	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate the source code for each feeder system (Sub-Project).
(61) NAME OF OUTSIDE ANCILLARY PROVIDER	446	475	30	LEFT/ALPHANUMERIC	YES	YES	
(62) ANCILLARY PROVIDER TAX ID NUMBER	476	495	20	LEFT/ALPHANUMERIC	YES	YES	
(63) SOURCE OF REFERRAL	496	501	6	LEFT/ALPHANUMERIC	NO	YES	Source of referral for inicident of care
(64) COUNTY ID	502	510	9	LEFT/ALPHANUMERIC	YES	NO	
(65) ATTENDING PHYSICIAN LICENSE NUMBER	511	519	9	LEFT/ALPHANUMERIC	NO	YES	
(66) REFERRING PHYSICIAN LICENSE NUMBER	520	528	9	LEFT/ALPHANUMERIC	NO	YES	
(67) OTHER PHYSICIAN LICENSE NUMBER	529	537	9	LEFT/ALPHANUMERIC	NO	YES	
(68) DRG CODE	538	543	6	LEFT/ALPHANUMERIC	NO	YES	
(69) PRINCIPAL DIAGNOSIS CODE	544	549	6	LEFT/ALPHANUMERIC	YES	NO	The condition which has been established to have been the chief cause of admission for care.
(70) ADMITTING DIAGNOSIS CODE	550	555	6	LEFT/ALPHANUMERIC	NO	YES	
(71) EXTERNAL CAUSE CODE	556	561	6	LEFT/ALPHANUMERIC	NO	YES	
(72) DISCHARGE DIAGNOSIS CODE	562	567	6	LEFT/ALPHANUMERIC	NO	YES	
(73) UNIQUE DIAGNOSIS COUNTER	568	569	2	RIGHT/NUMERIC	YES	YES	
(74) PROCEDURE CODING METHOD PRINCIPAL	570	570	1	RIGHT/NUMERIC	YES	YES	
(75) PROCEDURE CODE PRINCIPAL	571	576	6	LEFT/ALPHANUMERIC	YES	NO	The procedure which was performed for definitive treatment rather than diagnostic or exploratory purposes, unless these were the only types of procedures rendered during the event.
(76) PRIMARY REMARK CODE	577	578	2	LEFT/ALPHANUMERIC	YES	YES	
(77) PRIMARY VISIT CHARGE AMOUNT	579	588	10	RIGHT/NUMERIC	YES	NO	
(78) UNIQUE PROCEDURE COUNTER	589	591	3	RIGHT/NUMERIC	YES	YES	
(79) PROCEDURE QUANTITY 1	592	593	2	RIGHT/NUMERIC	YES	YES	
(80) PROCEDURE CODING METHOD 1	594	594	1	RIGHT/NUMERIC	YES	YES	

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(81) PROCEDURE CODE 1	595	600	6	LEFT/ALPHANUMERIC	YES	YES	
(82) ANCILLARY REMARK CODE 1	601	602	2	LEFT/ALPHANUMERIC	YES	YES	
(83) PROCEDURE CHARGE AMOUNT 1	603	612	10	RIGHT/NUMERIC	YES	YES	
(84) PROCEDURE QUANTITY 2	613	614	2	RIGHT/NUMERIC	YES	YES	
(85) PROCEDURE CODING METHOD 2	615	615	1	RIGHT/NUMERIC	YES	YES	
(86) PROCEDURE CODE 2	616	621	6	LEFT/ALPHANUMERIC	YES	YES	
(87) ANCILLARY REMARK CODE 2	622	623	2	LEFT/ALPHANUMERIC	YES	YES	
(88) PROCEDURE CHARGE AMOUNT 2	624	633	10	RIGHT/NUMERIC	YES	YES	
(89) PROCEDURE QUANTITY 3	634	635	2	RIGHT/NUMERIC	YES	YES	
(90) PROCEDURE CODING METHOD 3	636	636	1	RIGHT/NUMERIC	YES	YES	
(91) PROCEDURE CODE 3	637	642	6	LEFT/ALPHANUMERIC	YES	YES	
(92) ANCILLARY REMARK CODE 3	643	644	2	LEFT/ALPHANUMERIC	YES	YES	
(93) PROCEDURE CHARGE AMOUNT 3	645	654	10	RIGHT/NUMERIC	YES	YES	
(94) PROCEDURE QUANTITY 4	655	656	2	RIGHT/NUMERIC	YES	YES	
(95) PROCEDURE CODING METHOD 4	657	657	1	RIGHT/NUMERIC	YES	YES	
(96) PROCEDURE CODE 4	658	663	6	LEFT/ALPHANUMERIC	YES	YES	
(97) ANCILLARY REMARK CODE 4	664	665	2	LEFT/ALPHANUMERIC	YES	YES	
(98) PROCEDURE CHARGE AMOUNT 4	666	675	10	RIGHT/NUMERIC	YES	YES	
(99) PROCEDURE QUANTITY 5	676	677	2	RIGHT/NUMERIC	YES	YES	
(100) PROCEDURE CODING METHOD 5	678	678	1	RIGHT/NUMERIC	YES	YES	
(101) PROCEDURE CODE 5	679	684	6	LEFT/ALPHANUMERIC	YES	YES	
(102) ANCILLARY REMARK CODE 5	685	686	2	LEFT/ALPHANUMERIC	YES	YES	
(103) PROCEDURE CHARGE AMOUNT 5	687	696	10	RIGHT/NUMERIC	YES	YES	
(104) PROCEDURE QUANTITY 6	697	698	2	RIGHT/NUMERIC	YES	YES	
(105) PROCEDURE CODING METHOD 6	699	699	1	RIGHT/NUMERIC	YES	YES	
(106) PROCEDURE CODE 6	700	705	6	LEFT/ALPHANUMERIC	YES	YES	
(107) ANCILLARY REMARK CODE 6	706	707	2	LEFT/ALPHANUMERIC	YES	YES	
(108) PROCEDURE CHARGE AMOUNT 6	708	717	10	RIGHT/NUMERIC	YES	YES	
(109) PROCEDURE QUANTITY 7	718	719	2	RIGHT/NUMERIC	YES	YES	
(110) PROCEDURE CODING METHOD 7	720	720	1	RIGHT/NUMERIC	YES	YES	
(111) PROCEDURE CODE 7	721	726	6	LEFT/ALPHANUMERIC	YES	YES	

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(112) ANCILLARY REMARK CODE 7	727	728	2	LEFT/ALPHANUMERIC	YES	YES	
(113) PROCEDURE CHARGE AMOUNT 7	729	738	10	RIGHT/NUMERIC	YES	YES	
(114) PROCEDURE QUANTITY 8	739	740	2	RIGHT/NUMERIC	YES	YES	
(115) PROCEDURE CODING METHOD 8	741	741	1	RIGHT/NUMERIC	YES	YES	
(116) PROCEDURE CODE 8	742	747	6	LEFT/ALPHANUMERIC	YES	YES	
(117) ANCILLARY REMARK CODE 8	748	749	2	LEFT/ALPHANUMERIC	YES	YES	
(118) PROCEDURE CHARGE AMOUNT 8	750	759	10	RIGHT/NUMERIC	YES	YES	
(119) PROCEDURE QUANTITY 9	760	761	2	RIGHT/NUMERIC	YES	YES	
(120) PROCEDURE CODING METHOD 9	762	762	1	RIGHT/NUMERIC	YES	YES	
(121) PROCEDURE CODE 9	763	768	6	LEFT/ALPHANUMERIC	YES	YES	
(122) ANCILLARY REMARK CODE 9	769	770	2	LEFT/ALPHANUMERIC	YES	YES	
(123) PROCEDURE CHARGE AMOUNT 9	771	780	10	RIGHT/NUMERIC	YES	YES	
(124) PROCEDURE QUANTITY 10	781	782	2	RIGHT/NUMERIC	YES	YES	
(125) PROCEDURE CODING METHOD 10	783	783	1	RIGHT/NUMERIC	YES	YES	
(126) PROCEDURE CODE 10	784	789	6	LEFT/ALPHANUMERIC	YES	YES	
(127) ANCILLARY REMARK CODE 10	790	791	2	LEFT/ALPHANUMERIC	YES	YES	
(128) PROCEDURE CHARGE AMOUNT 10	792	801	10	RIGHT/NUMERIC	YES	YES	
(129) PROCEDURE QUANTITY 11	802	803	2	RIGHT/NUMERIC	YES	YES	
(130) PROCEDURE CODING METHOD 11	804	804	1	RIGHT/NUMERIC	YES	YES	
(131) PROCEDURE CODE 11	805	810	6	LEFT/ALPHANUMERIC	YES	YES	
(132) ANCILLARY REMARK CODE 11	811	812	2	LEFT/ALPHANUMERIC	YES	YES	
(133) PROCEDURE CHARGE AMOUNT 11	813	822	10	RIGHT/NUMERIC	YES	YES	
(134) PROCEDURE QUANTITY 12	823	824	2	RIGHT/NUMERIC	YES	YES	
(135) PROCEDURE CODING METHOD 12	825	825	1	RIGHT/NUMERIC	YES	YES	
(136) PROCEDURE CODE 12	826	831	6	LEFT/ALPHANUMERIC	YES	YES	
(137) ANCILLARY REMARK CODE 12	832	833	2	LEFT/ALPHANUMERIC	YES	YES	
(138) PROCEDURE CHARGE AMOUNT 12	834	843	10	RIGHT/NUMERIC	YES	YES	
(139) PROCEDURE QUANTITY 13	844	845	2	RIGHT/NUMERIC	YES	YES	
(140) PROCEDURE CODING METHOD 13	846	846	1	RIGHT/NUMERIC	YES	YES	
(141) PROCEDURE CODE 13	847	852	6	LEFT/ALPHANUMERIC	YES	YES	
(142) ANCILLARY REMARK CODE 13	853	854	2	LEFT/ALPHANUMERIC	YES	YES	
(143) PROCEDURE CHARGE AMOUNT 13	855	864	10	RIGHT/NUMERIC	YES	YES	
(144) INPATIENT CHARGE COUNTER	865	865	1	LEFT/ALPHANUMERIC	YES	YES	
(145) CANCELLATION DATE	866	873	8	DATE	YES	YES	

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION
(146) REFUND/CANCELLED	874	874	1	RIGHT/NUMERIC	YES	YES	
(147) AIA POLICY NUMBER	875	884	10	LEFT/ALPHANUMERIC	YES	NO	AIA Policy Number is used to define the policy number for each CP program on the label of CD and data set file of claims submitted by AIA.
(148) FISCAL YEAR DATE	885	889	5	LEFT/ALPHANUMERIC	YES	NO	The Fiscal Year Date is used to identify the Fiscal Year the CP claim(s) were processed by AIA for each program policy.
(149) AIA CLAIM TYPE	890	890	1	LEFT/ALPHANUMERIC	YES	NO	The AIA Claim Type is used to identify the type of claim per visit by the patient for all CP programs.
(150) AIA RECEIVED DATE	891	898	8	DATE	YES	NO	The AIA Received Date is used to identify the date AIA received the claim(s) data from the CP agencies.
(151) SPA NUMBER	899	900	2	LEFT/ALPHANUMERIC	YES	?	
(152) SUPERVISORY NUMBER	901	902	2	LEFT/ALPHANUMERIC	YES	?	
(153) MANUAL/ELECTRONIC	903	903	1	LEFT/ALPHANUMERIC	YES	YES	
(154) ON-SITE	904	904	1	LEFT/ALPHANUMERIC	YES	?	
(155) CONTRACT NUMBER	905	911	7	LEFT/ALPHANUMERIC	YES	?	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(1) PATIENT LAST NAME	1	20	20	LEFT/ALPHANUMERIC	YES	NO	The full surname or family name of the patient.	
(2) PATIENT FIRST NAME	21	35	15	LEFT/ALPHANUMERIC	YES	NO	The full first or given name of the patient, minimally the first name initial.	
(3) PATIENT MIDDLE NAME	36	50	15	LEFT/ALPHANUMERIC	YES	YES	The full middle name of the patient when it is available. Minimally, the middle name initial.	
(4) DATE OF BIRTH	51	58	8	DATE	YES	NO	The month, day, century and year of a person's birth. Used to calculate age at the time of an event.	FORMAT: MMDDCCYY
(5) SEX	59	59	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate gender.	(2=Female, 1=Male, 0=Unknown)
(6) RACE/ETHNICITY	60	60	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate race or ethnicity.	
(7) PATIENT MARITAL STATUS	61	61	1	LEFT/ALPHANUMERIC	NO	YES		
(8) PRIMARY LANGUAGE CODE	62	63	2	LEFT/ALPHANUMERIC	YES	NO		
(9) PERMANENT FILE NUMBER (MRUN)	64	72	9	LEFT/ALPHANUMERIC	NO	YES	Permanent file # assigned by each facility to a patient record.	
(10) PATIENT ACCOUNT NUMBER	73	86	14	LEFT/ALPHANUMERIC	YES	NO	Patient account number is generated and assigned by an individual CP program contractor for each submitted claim. It is the internal medical record number of an identified CP program provider.	
(11) MOTHER MAIDEN NAME	87	106	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the mother of the patient.	
(12) MOTHER FIRST NAME	107	121	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the mother of the patient.	
(13) FATHER LAST NAME	122	141	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the father of the patient.	
(14) FATHER FIRST NAME	142	156	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the father of the patient.	
(15) SOCIAL SECURITY NUMBER	157	166	10	LEFT/ALPHANUMERIC	YES	NO	The patient's social security number.	
(16) MEDI - CAL IDENTIFICATION NUMBER	167	181	15	LEFT/ALPHANUMERIC	YES	YES	The Medi-Cal identifier issued by the State of California to the patient receiving medical services.	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(17) PATIENT ADDRESS	182	216	35	LEFT/ALPHANUMERIC	YES	NO	The street number and street name, including street direction and apt. designation, of usual or permanent address.	
(18) PATIENT CITY	217	236	20	LEFT/ALPHANUMERIC	YES	NO	The name of the city or town where the patient resides.	
(19) PATIENT STATE	237	238	2	LEFT/ALPHANUMERIC	YES	NO	The name of the state where the patient resides.	
(20) PATIENT ZIP	239	243	5	LEFT/ALPHANUMERIC	YES	NO	Zip code of patient's usual or permanent address.	Patient zip code will have a value of '99999' when patient address is
(21) PATIENT BIRTH PLACE	244	263	20	LEFT/ALPHANUMERIC	NO	YES	The name of city, town, village, state, and/or country the patient was born.	
(22) FAMILY SIZE	264	265	2	RIGHT/NUMERIC	NO	YES	Based on ATP faimily size definition.	
(23) MONTHLY INCOME	266	272	7	RIGHT/NUMERIC	NO	YES	The total monthly income received for the previous month by all related family members residing with patient(s).	
(24) SOURCE OF INCOME	273	273	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the primary or largest single source of family income.	
(25) TYPE OF EMPLOYMENT	274	274	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the occupation of the patient's family primary wage earner.	
(26) SERVICE SETTING CODE	275	276	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate a provider service setting.	
(27) SERVICE UNITS CODE	277	278	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate the type of unit of medical service.	
(28) SERVICE UNITS QUANTITY	279	282	4	LEFT/ALPHANUMERIC	YES	YES	The number of units of service provided during an incident of medical service.	
(29) EMERGENCY ROOM PRIORITY FLAG	283	283	1	LEFT/ALPHANUMERIC	NO	YES	A flag indicating that an immediate action or remedy is required. This distinguishes emergency and non-emergency.	
(30) DISCHARGE DISPOSITION CODE	284	285	2	LEFT/ALPHANUMERIC	YES	YES		DEFAULT VALUE = "8"
(31) DISCHARGE DATE	286	293	8	DATE	YES	YES		FORMAT: MMDDCCYY
(32) TYPE OF INPATIENT ADMISSION CODE	294	295	2	LEFT/ALPHANUMERIC	YES	YES		
(33) ADMIT DATE	296	303	8	DATE	YES	NO		FORMAT: MMDDCCYY

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(34) DATE OF INITIAL CLINIC VISIT	304	311	8	DATE	NO	YES		FORMAT: MMDDCCYY
(35) TYPE OF OUTPATIENT SERVICE	312	313	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate different outpatient service category by the care rendered or the specialty of the provider (e.g., clinic code, medical service, etc.)	
(36) CLINIC CODE	314	318	5	LEFT/ALPHANUMERIC	NO	YES	The code which specifies hospital outpatient clinic or comprehensive health clinic or community (free-standing) clinic providing services (applicable to sub-projects).	
(37) ENCOUNTER CHARGE CODE	319	328	10	LEFT/ALPHANUMERIC	NO	YES		
(38) TRAUMA PATIENT SEQUENCE NUMBER	329	336	8	LEFT/ALPHANUMERIC	NO	YES	This field is an eight (8) digit code assigned to trauma patients treated at designated trauma hospitals.	
(39) ENCOUNTER PATIENT SERVICE CODE	337	343	7	LEFT/ALPHANUMERIC	NO	YES		
(40) NURSING UNIT	344	349	6	LEFT/ALPHANUMERIC	NO	YES		
(41) REMITTANCE ADVICE DATE	350	357	8	DATE	YES	YES		FORMAT: MMDDCCYY
(42) CURRENT CONDITION CODE	358	358	1	LEFT/ALPHANUMERIC	NO	YES		
(43) FAMILY PLANNING INDICATOR	359	359	1	LEFT/ALPHANUMERIC	NO	YES		
(44) ANCILLARY FLAG	360	360	1	LEFT/ALPHANUMERIC	YES	YES		
(45) EPSDT INDICATOR	361	361	1	LEFT/ALPHANUMERIC	NO	YES		
(46) SERVICE EVENT CHARGE AMOUNT	362	370	9	RIGHT/NUMERIC	YES	YES	The amount charged to a patient for medical services delivered during a service event.	
(47) AMOUNT PAID	371	379	9	RIGHT/NUMERIC	YES	YES	The total dollars expended for defined units of service rendered to county patients (OP visits, IP days, ancillaries)	AS OF FY0809, $0 (ZERO) DOLLAR CLAIMS WILL BE INCLUDED IN THE DATA AND A 'BLANK' FIELD IS A DENIED

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(48) CLAIM NUMBER	380	394	15	LEFT/ALPHANUMERIC	YES	NO	Claim number is generated and assigned by AIA for each claim submitted. The claim number sequence is patient specific. A patient can potentially have 9,999 claims submitted per fiscal year.	
(49) CARRIER CODE/PRIMARY	395	397	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by different facilities. (Three occurences: Primary carrier code, and two others: Secondary carrier code and tertiary carrier code)	
(50) CARRIER CODE/SECONDARY	398	400	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by facility.	
(51) CARRIER CODE/TERTIARY	401	403	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by facility.	
(52) TOTAL ALLOWABLE AMOUNT	404	412	9	LEFT/ALPHANUMERIC	NO	YES		
(53) GENERAL RELIEF ID NUMBER	413	426	14	LEFT/ALPHANUMERIC	YES	YES		
(54) HOMELESS CODE	427	428	2	LEFT/ALPHANUMERIC	YES	NO	A code used to define a patient's living arrangement and/or status at the time of a submitted claim to an agency in the CP program.	Homeless Code values are: NH=Not Homeless, HS=Homeless-Staying at a shelter, HO=Homeless-Living outside, OT=Homeless-Other living arrangements, HU=Homeless-Unable to
(55) FUND CODE	429	429	1	LEFT/ALPHANUMERIC	YES	NO	A code used to define the program a patient is enrolled in and monies processed from such as Primary, HWLAP, SB474 (SPA6), HWLAS, Specialty, CCEP, and CCES.	As of FY0708, Fund Code values were the following: Primary ('P', 'H', 'S', 'D'). As of FY0809, Fund Code values per program were the following: Primary ('P', 'H', 'L'); HWLAP ('H', 'L', 'A', 'D'); HWLAS ('S'); SB474 ('S', 'D'); Specialty ('S'); CCEP ('C'); and CCES ('S'). As of FY1112, Fund Code values per program are the following: ????
(56) FILLER	430	430	1	N/A	NO	YES		
(57) FACILITY ID	431	439	9	LEFT/ALPHANUMERIC	YES	NO		AIA SENDS THE FACILITIES' TAX ID. THEY STATED THAT THEY DISTINGUISH MULTIPLE FACILITIES WITH SAME TAX ID BY A SUFFIX, WHICH HAS BEEN ADDED BELOW.
(58) FACILITY ID SUFFIX	440	441	2	LEFT/ALPHANUMERIC	YES	NO		AIA USES A ONE-CHARACTER ALPHA VALUE
(59) SOURCE OF ADMISSION	442	443	2	LEFT/ALPHANUMERIC	NO	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(60) RECORD SOURCE	444	445	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate the source code for each feeder system (Sub-Project).	
(61) NAME OF OUTSIDE ANCILLARY PROVIDER	446	475	30	LEFT/ALPHANUMERIC	YES	YES		
(62) ANCILLARY PROVIDER TAX ID NUMBER	476	495	20	LEFT/ALPHANUMERIC	YES	YES		
(63) SOURCE OF REFERRAL	496	501	6	LEFT/ALPHANUMERIC	NO	YES	Source of referral for inicident of care	
(64) COUNTY ID	502	510	9	LEFT/ALPHANUMERIC	YES	NO		CHANGED AS OF 8-20-03 FROM ADMITTING PHYSICIAN LICENSE NUMBER TO COUNTY ID (AKA: SITEID)
(65) ATTENDING PHYSICIAN LICENSE NUMBER	511	519	9	LEFT/ALPHANUMERIC	NO	YES		
(66) REFERRING PHYSICIAN LICENSE NUMBER	520	528	9	LEFT/ALPHANUMERIC	NO	YES		
(67) OTHER PHYSICIAN LICENSE NUMBER	529	537	9	LEFT/ALPHANUMERIC	NO	YES		
(68) DRG CODE	538	543	6	LEFT/ALPHANUMERIC	NO	YES		
(69) PRINCIPAL DIAGNOSIS CODE	544	549	6	LEFT/ALPHANUMERIC	YES	NO	The condition which has been established to have been the chief cause of admission for care.	
(70) ADMITTING DIAGNOSIS CODE	550	555	6	LEFT/ALPHANUMERIC	NO	YES		
(71) EXTERNAL CAUSE CODE	556	561	6	LEFT/ALPHANUMERIC	NO	YES		
(72) DISCHARGE DIAGNOSIS CODE	562	567	6	LEFT/ALPHANUMERIC	NO	YES		
(73) UNIQUE DIAGNOSIS COUNTER	568	569	2	RIGHT/NUMERIC	YES	YES		DEFAULT VALUE = "0"
(74) PROCEDURE CODING METHOD PRINCIPAL	570	570	1	RIGHT/NUMERIC	YES	YES		
(75) PROCEDURE CODE PRINCIPAL	571	576	6	LEFT/ALPHANUMERIC	YES	NO	The procedure which was performed for definitive treatment rather than diagnostic or exploratory purposes, unless these were the only types of procedures rendered during the event.	PRIMARY ENCOUNTER/E&M CODE: CPT CODE VALUES RANGE FROM 99201 TO 99215.
(76) PRIMARY REMARK CODE	577	578	2	LEFT/ALPHANUMERIC	YES	YES		REMARK CODE TABLE FOR PRIMARY REMARK CODE AND ANCILLARY REMARK
(77) PRIMARY VISIT CHARGE AMOUNT	579	588	10	RIGHT/NUMERIC	YES	NO		ENCOUNTER CHARGE
(78) UNIQUE PROCEDURE COUNTER	589	591	3	RIGHT/NUMERIC	YES	YES		DEFAULT VALUE = '1', ONE ENCOUNTER
(79) PROCEDURE QUANTITY 1	592	593	2	RIGHT/NUMERIC	YES	YES		ANCILLARY LINE ITEMS (SERIES 79 -83): DEFAULT VALUE '1'
(80) PROCEDURE CODING METHOD 1	594	594	1	RIGHT/NUMERIC	YES	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(81) PROCEDURE CODE 1	595	600	6	LEFT/ALPHANUMERIC	YES	YES		FILLED WITH A CPT CODE
(82) ANCILLARY REMARK CODE 1	601	602	2	LEFT/ALPHANUMERIC	YES	YES		REMARK CODE TABLE FOR PRIMARY REMARK CODE AND ANCILLARY REMARK CODE 1-13 PROVIDED
(83) PROCEDURE CHARGE AMOUNT 1	603	612	10	RIGHT/NUMERIC	YES	YES		PER ANCILLARY CODE THERE IS A CHARGE
(84) PROCEDURE QUANTITY 2	613	614	2	RIGHT/NUMERIC	YES	YES		
(85) PROCEDURE CODING METHOD 2	615	615	1	RIGHT/NUMERIC	YES	YES		
(86) PROCEDURE CODE 2	616	621	6	LEFT/ALPHANUMERIC	YES	YES		
(87) ANCILLARY REMARK CODE 2	622	623	2	LEFT/ALPHANUMERIC	YES	YES		
(88) PROCEDURE CHARGE AMOUNT 2	624	633	10	RIGHT/NUMERIC	YES	YES		
(89) PROCEDURE QUANTITY 3	634	635	2	RIGHT/NUMERIC	YES	YES		
(90) PROCEDURE CODING METHOD 3	636	636	1	RIGHT/NUMERIC	YES	YES		
(91) PROCEDURE CODE 3	637	642	6	LEFT/ALPHANUMERIC	YES	YES		
(92) ANCILLARY REMARK CODE 3	643	644	2	LEFT/ALPHANUMERIC	YES	YES		
(93) PROCEDURE CHARGE AMOUNT 3	645	654	10	RIGHT/NUMERIC	YES	YES		
(94) PROCEDURE QUANTITY 4	655	656	2	RIGHT/NUMERIC	YES	YES		
(95) PROCEDURE CODING METHOD 4	657	657	1	RIGHT/NUMERIC	YES	YES		
(96) PROCEDURE CODE 4	658	663	6	LEFT/ALPHANUMERIC	YES	YES		
(97) ANCILLARY REMARK CODE 4	664	665	2	LEFT/ALPHANUMERIC	YES	YES		
(98) PROCEDURE CHARGE AMOUNT 4	666	675	10	RIGHT/NUMERIC	YES	YES		
(99) PROCEDURE QUANTITY 5	676	677	2	RIGHT/NUMERIC	YES	YES		
(100) PROCEDURE CODING METHOD 5	678	678	1	RIGHT/NUMERIC	YES	YES		
(101) PROCEDURE CODE 5	679	684	6	LEFT/ALPHANUMERIC	YES	YES		
(102) ANCILLARY REMARK CODE 5	685	686	2	LEFT/ALPHANUMERIC	YES	YES		
(103) PROCEDURE CHARGE AMOUNT 5	687	696	10	RIGHT/NUMERIC	YES	YES		
(104) PROCEDURE QUANTITY 6	697	698	2	RIGHT/NUMERIC	YES	YES		
(105) PROCEDURE CODING METHOD 6	699	699	1	RIGHT/NUMERIC	YES	YES		
(106) PROCEDURE CODE 6	700	705	6	LEFT/ALPHANUMERIC	YES	YES		
(107) ANCILLARY REMARK CODE 6	706	707	2	LEFT/ALPHANUMERIC	YES	YES		
(108) PROCEDURE CHARGE AMOUNT 6	708	717	10	RIGHT/NUMERIC	YES	YES		
(109) PROCEDURE QUANTITY 7	718	719	2	RIGHT/NUMERIC	YES	YES		
(110) PROCEDURE CODING METHOD 7	720	720	1	RIGHT/NUMERIC	YES	YES		
(111) PROCEDURE CODE 7	721	726	6	LEFT/ALPHANUMERIC	YES	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(112) ANCILLARY REMARK CODE 7	727	728	2	LEFT/ALPHANUMERIC	YES	YES		
(113) PROCEDURE CHARGE AMOUNT 7	729	738	10	RIGHT/NUMERIC	YES	YES		
(114) PROCEDURE QUANTITY 8	739	740	2	RIGHT/NUMERIC	YES	YES		
(115) PROCEDURE CODING METHOD 8	741	741	1	RIGHT/NUMERIC	YES	YES		
(116) PROCEDURE CODE 8	742	747	6	LEFT/ALPHANUMERIC	YES	YES		
(117) ANCILLARY REMARK CODE 8	748	749	2	LEFT/ALPHANUMERIC	YES	YES		
(118) PROCEDURE CHARGE AMOUNT 8	750	759	10	RIGHT/NUMERIC	YES	YES		
(119) PROCEDURE QUANTITY 9	760	761	2	RIGHT/NUMERIC	YES	YES		
(120) PROCEDURE CODING METHOD 9	762	762	1	RIGHT/NUMERIC	YES	YES		
(121) PROCEDURE CODE 9	763	768	6	LEFT/ALPHANUMERIC	YES	YES		
(122) ANCILLARY REMARK CODE 9	769	770	2	LEFT/ALPHANUMERIC	YES	YES		
(123) PROCEDURE CHARGE AMOUNT 9	771	780	10	RIGHT/NUMERIC	YES	YES		
(124) PROCEDURE QUANTITY 10	781	782	2	RIGHT/NUMERIC	YES	YES		
(125) PROCEDURE CODING METHOD 10	783	783	1	RIGHT/NUMERIC	YES	YES		
(126) PROCEDURE CODE 10	784	789	6	LEFT/ALPHANUMERIC	YES	YES		
(127) ANCILLARY REMARK CODE 10	790	791	2	LEFT/ALPHANUMERIC	YES	YES		
(128) PROCEDURE CHARGE AMOUNT 10	792	801	10	RIGHT/NUMERIC	YES	YES		
(129) PROCEDURE QUANTITY 11	802	803	2	RIGHT/NUMERIC	YES	YES		
(130) PROCEDURE CODING METHOD 11	804	804	1	RIGHT/NUMERIC	YES	YES		
(131) PROCEDURE CODE 11	805	810	6	LEFT/ALPHANUMERIC	YES	YES		
(132) ANCILLARY REMARK CODE 11	811	812	2	LEFT/ALPHANUMERIC	YES	YES		
(133) PROCEDURE CHARGE AMOUNT 11	813	822	10	RIGHT/NUMERIC	YES	YES		
(134) PROCEDURE QUANTITY 12	823	824	2	RIGHT/NUMERIC	YES	YES		
(135) PROCEDURE CODING METHOD 12	825	825	1	RIGHT/NUMERIC	YES	YES		
(136) PROCEDURE CODE 12	826	831	6	LEFT/ALPHANUMERIC	YES	YES		
(137) ANCILLARY REMARK CODE 12	832	833	2	LEFT/ALPHANUMERIC	YES	YES		
(138) PROCEDURE CHARGE AMOUNT 12	834	843	10	RIGHT/NUMERIC	YES	YES		
(139) PROCEDURE QUANTITY 13	844	845	2	RIGHT/NUMERIC	YES	YES		
(140) PROCEDURE CODING METHOD 13	846	846	1	RIGHT/NUMERIC	YES	YES		
(141) PROCEDURE CODE 13	847	852	6	LEFT/ALPHANUMERIC	YES	YES		
(142) ANCILLARY REMARK CODE 13	853	854	2	LEFT/ALPHANUMERIC	YES	YES		
(143) PROCEDURE CHARGE AMOUNT 13	855	864	10	RIGHT/NUMERIC	YES	YES		
(144) INPATIENT CHARGE COUNTER	865	865	1	LEFT/ALPHANUMERIC	YES	YES		
(145) CANCELLATION DATE	866	873	8	DATE	YES	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PRIMARY CARE CLAIMS (PRIMARY, HWLAP, HWLAS, SB474, SPECIALTY, CCEP, CCES)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(146) REFUND/CANCELLED	874	874	1	RIGHT/NUMERIC	YES	YES		VALUES ARE "R" FOR PARTIAL REFUND AND "C" CANCELLED CLAIM
(147) AIA POLICY NUMBER	875	884	10	LEFT/ALPHANUMERIC	YES	NO	AIA Policy Number is used to define the policy number for each CP program on the label of CD and data set file of claims submitted by AIA.	FORMAT: XXXNNN - AIA Policy Number per program is as follows: Primary ('PPP078', 'PPP089', 'PPP090', 'PPP101', 'PPP112', etc); HWLAP ('PPW089', 'PPW090', 'PPW101', 'PPW112', etc); HWLAS ('PPH089', 'PPH090', 'PPH101', 'PPH112', etc); SB474 ('PPB089', 'PPB090', 'PPB101', 'PPB112', etc); Specialty ('PPS089', 'PPS090', 'PPS101', 'PPS112', etc); CCEP ('PPC090', 'PPC101', 'PPC112', etc); and CCES ('PPY090', 'PPY101', 'PPY112', etc)
(148) FISCAL YEAR DATE	885	889	5	LEFT/ALPHANUMERIC	YES	NO	The Fiscal Year Date is used to identify the Fiscal Year the CP claim(s) were processed by AIA for each program policy.	FORMAT: YY-YY
(149) AIA CLAIM TYPE	890	890	1	LEFT/ALPHANUMERIC	YES	NO	The AIA Claim Type is used to identify the type of claim per visit by the patient for all CP programs.	VALUES ARE "P" FOR PPP, "A" FOR ANCILLARY, AND "D" FOR DRUG
(150) AIA RECEIVED DATE	891	898	8	DATE	YES	NO	The AIA Received Date is used to identify the date AIA received the claim(s) data from the CP agencies.	FORMAT: MMDDCCYY
(151) SPA NUMBER	899	900	2	LEFT/ALPHANUMERIC	YES	?		CLINIC LOCATION
(152) SUPERVISORY NUMBER	901	902	2	LEFT/ALPHANUMERIC	YES	?		SUPERVISORY DISTRICT NUMBER
(153) MANUAL/ELECTRONIC	903	903	1	LEFT/ALPHANUMERIC	YES	YES		DEFAULT VALUES ARE 'M' OR 'E'
(154) ON-SITE	904	904	1	LEFT/ALPHANUMERIC	YES	?		VALUES ARE 'Y' = ON-SITE - NO PAYMENT DUE TO CLINIC FOR ANCILLARY CHARGES; AND, 'N' = OFF-SITE - PAYMENT DUE TO CLINIC FOR ANCILLARY CHARGES.
(155) CONTRACT NUMBER	905	911	7	LEFT/ALPHANUMERIC	YES	?		CLINIC CONTRACT NUMBER

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(1) PATIENT LAST NAME	1	20	20	LEFT/ALPHANUMERIC	YES	NO	The full surname or family name of the patient.	
(2) PATIENT FIRST NAME	21	35	15	LEFT/ALPHANUMERIC	YES	NO	The full first or given name of the patient, minimally the first name initial.	
(3) PATIENT MIDDLE NAME	36	50	15	LEFT/ALPHANUMERIC	YES	YES	The full middle name of the patient when it is available. Minimally, the middle name	
(4) DATE OF BIRTH	51	58	8	DATE	YES	NO	The month, day, century and year of a person's birth. Used to calculate age at the time of an event.	
(5) SEX	59	59	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate gender.	
(6) RACE/ETHNICITY	60	60	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate race or ethnicity.	
(7) PATIENT MARITAL STATUS	61	61	1	LEFT/ALPHANUMERIC	NO	YES		
(8) PRIMARY LANGUAGE CODE	62	63	2	LEFT/ALPHANUMERIC	YES	NO		
(9) PERMANENT FILE NUMBER (MRUN)	64	72	9	LEFT/ALPHANUMERIC	NO	YES	Permanent file # assigned by each facility to a patient record.	
(10) PATIENT ACCOUNT NUMBER	73	86	14	LEFT/ALPHANUMERIC	YES	NO	Patient account number is generated and assigned by an individual CP program contractor for each submitted claim. It is the internal medical record number of an identified CP	
(11) MOTHER MAIDEN NAME	87	106	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the mother of the patient.	
(12) MOTHER FIRST NAME	107	121	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the mother of the patient.	
(13) FATHER LAST NAME	122	141	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the father of the patient.	
(14) FATHER FIRST NAME	142	156	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the father of the patient.	
(15) SOCIAL SECURITY NUMBER	157	166	10	LEFT/ALPHANUMERIC	YES	NO	The patient's social security number.	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(16) MEDI - CAL IDENTIFICATION NUMBER	167	181	15	LEFT/ALPHANUMERIC	YES	YES	The Medi-Cal identifier issued by the State of California to the patient receiving medical services.	
(17) PATIENT ADDRESS	182	216	35	LEFT/ALPHANUMERIC	YES	NO	The street number and street name, including street direction and apt. designation, of usual or permanent address.	
(18) PATIENT CITY	217	236	20	LEFT/ALPHANUMERIC	YES	NO	The name of the city or town where the patient resides.	
(19) PATIENT STATE	237	238	2	LEFT/ALPHANUMERIC	YES	NO	The name of the state where the patient resides.	
(20) PATIENT ZIP CODE	239	243	5	LEFT/ALPHANUMERIC	YES	NO	Zip code of patient's usual or permanent address.	WHEN PATIENT ZIP CODE = '99999' THEN PATIENT ADDRESS IS NOT KNOWN, PER AIA
(21) PATIENT BIRTH PLACE	244	263	20	LEFT/ALPHANUMERIC	NO	YES	The name of city, town, village, state, and/or country the patient was born.	
(22) FAMILY SIZE	264	265	2	RIGHT/NUMERIC	NO	YES	Based on ATP faimily size definition.	
(23) MONTHLY INCOME	266	272	7	RIGHT/NUMERIC	NO	YES	The total monthly income received for the previous month by all related family members residing with patient(s).	
(24) SOURCE OF INCOME	273	273	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the primary or largest single source of family income.	
(25) TYPE OF EMPLOYMENT	274	274	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the occupation of the patient's family primary wage earner.	
(26) SERVICE SETTING CODE	275	276	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate a provider service setting.	DEFAULT "14" FOR DENTAL
(27) SERVICE UNITS CODE	277	278	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate the type of unit of medical service.	DEFAULT "2" FOR VISIT, LEADING SPACE
(28) SERVICE UNITS QUANTITY	279	282	4	LEFT/ALPHANUMERIC	YES	YES	The number of units of service provided during an incident of medical service.	DEFAULT "1", LEADING SPACE

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(29) EMERGENCY ROOM PRIORITY FLAG	283	283	1	LEFT/ALPHANUMERIC	NO	YES	A flag indicating that an immediate action or remedy is required. This distinguishes emergency and non-emergency.	
(30) DISCHARGE DISPOSITION CODE	284	285	2	LEFT/ALPHANUMERIC	YES	YES		DEFAULT "8" FOR VISIT, TRAILING
(31) BILLING THRU DATE	286	293	8	DATE	YES	YES		TOGETHER WITH BILLING FROM DATE, EQUALS THE TOTAL RANGE OF SERVICE FROM AND SERVICE THRU DATES.
(32) TYPE OF INPATIENT ADMISSION CODE	294	295	2	LEFT/ALPHANUMERIC	NO	YES		
(33) BILLING FROM DATE	296	303	8	DATE	YES	NO		TOGETHER WITH BILLING THRU DATE, EQUALS THE TOTAL RANGE OF SERVICE FROM AND SERVICE THRU DATES.
(34) DATE OF INITIAL CLINIC VISIT	304	311	8	DATE	NO	YES		
(35) TYPE OF OUTPATIENT SERVICE	312	313	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate different outpatient service category by the care rendered or the specialty of the provider (e.g., clinic code, medical service, etc.)	DEFAULT "4" FOR DENTAL, LEADING SPACES
(36) CLINIC CODE	314	318	5	LEFT/ALPHANUMERIC	NO	YES	The code which specifies hospital outpatient clinic or comprehensive health clinic or community (free-standing) clinic providing services (applicable to sub-projects).	
(37) ENCOUNTER CHARGE CODE	319	328	10	LEFT/ALPHANUMERIC	NO	YES		
(38) TRAUMA PATIENT SEQUENCE NUMBER	329	336	8	LEFT/ALPHANUMERIC	NO	YES		
(39) ENCOUNTER PATIENT SERVICE CODE	337	343	7	LEFT/ALPHANUMERIC	NO	YES		
(40) NURSING UNIT	344	349	6	LEFT/ALPHANUMERIC	NO	YES		
(41) REMITTANCE ADVICE DATE	350	357	8	DATE	YES	YES		
(42) CURRENT CONDITION CODE	358	358	1	LEFT/ALPHANUMERIC	NO	YES		
(43) FAMILY PLANNING INDICATOR	359	359	1	LEFT/ALPHANUMERIC	NO	YES		
(44) ANCILLARY FLAG	360	360	1	LEFT/ALPHANUMERIC	NO	YES		
(45) EPSDT INDICATOR	361	361	1	LEFT/ALPHANUMERIC	NO	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(46) SERVICE EVENT CHARGE AMOUNT	362	370	9	RIGHT/NUMERIC	YES	NO	The amount charged to a patient for medical services delivered during a service event.	(FORMAT 9.2, IMPLIED DECIMAL)
(47) AMOUNT PAID	371	379	9	RIGHT/NUMERIC	YES	YES	The total dollars expended for defined units of service rendered to county patients (OP visits, IP days, ancillaries)	(FORMAT 9.2, IMPLIED DECIMAL)
(48) CLAIM NUMBER	380	394	15	LEFT/ALPHANUMERIC	YES	NO	Claim number is generated and assigned by AIA for each claim submitted. The claim number sequence is patient specific. Dental claims have an 11-byte string generated as a composite year, day and claim number.	NOT UNIQUE, BASED ON THE NUMBER OF CLAIMS PER PATIENT.
(49) CARRIER CODE/PRIMARY	395	397	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by different facilities. (Three occurences: Primary carrier code, and two others: Secondary carrier code and tertiary carrier code)	
(50) CARRIER CODE/SECONDARY	398	400	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by facility.	
(51) CARRIER CODE/TERTIARY	401	403	3	LEFT/ALPHANUMERIC	NO	YES	A billing code assigned by facility.	
(52) TOTAL ALLOWABLE AMOUNT	404	412	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) SUM OF LINE ITEM
(53) GENERAL RELIEF ID NUMBER	413	426	14	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL CLAIMS DO NOT INCLUDE GENERAL RELIEF PATIENTS.
(54) HOMELESS CODE	427	428	2	LEFT/ALPHANUMERIC	YES	NO	A code used to define a patient's living arrangement and/or status at the time of a submitted claim to an agency in the CP program.	Homeless Code values are: NH=Not Homeless, HS=Homeless-Staying at a shelter, HO=Homeless-Living outside, OT=Homeless-Other living arrangements, HU=Homeless-Unable to specify further, UN=Unable to determine

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(55) FUND CODE	429	429	1	LEFT/ALPHANUMERIC	YES	NO	A code used to define the program a patient is enrolled in and monies processed.	VALUE FOR DENTAL = 'D'
(56) FILLER	430	430	1	N/A	NO	YES		
(57) FACILITY ID	431	439	9	LEFT/ALPHANUMERIC	YES	NO		AIA SENDS THE FACILITIES' TAX ID. AIA STATED THAT THEY DISTINGUISH MULTIPLE FACILITIES WITH THE SAME TAX ID BY A SUFFIX, WHICH HAS BEEN ADDED BELOW.
(58) FACILITY ID SUFFIX	440	441	2	LEFT/ALPHANUMERIC	YES	NO		AIA USES A ONE-CHARACTER ALPHA VALUE
(59) SOURCE OF ADMISSION	442	443	2	LEFT/ALPHANUMERIC	NO	YES		
(60) RECORD SOURCE	444	445	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate the source code for each feeder system (Sub-Project).	DEFAULT "21" FOR P/PP DENTAL
(61) NAME OF OUTSIDE ANCILLARY PROVIDER	446	475	30	LEFT/ALPHANUMERIC	NO	YES		
(62) ANCILLARY PROVIDER TAX ID NUMBER	476	495	20	LEFT/ALPHANUMERIC	NO	YES		
(63) SOURCE OF REFERRAL	496	501	6	LEFT/ALPHANUMERIC	NO	YES	Source of referral for inicident of care	
(64) COUNTY ID	502	510	9	LEFT/ALPHANUMERIC	YES	NO		CHANGED AS OF 8-20-03 FROM ADMITTING PHYSICIAN LICENSE NUMBER TO COUNTY ID (AKA: SITEID)
(65) ADMITTING PHYSICIAN LICENSE NUMBER	511	519	9	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL FACILITIES DO NOT REPORT ANY PHYSICIAN DATA
(66) REFERRING PHYSICIAN LICENSE NUMBER	520	528	9	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL FACILITIES DO NOT REPORT ANY PHYSICIAN DATA
(67) OTHER PHYSICIAN LICENSE NUMBER	529	537	9	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL FACILITIES DO NOT REPORT ANY
(68) DRG CODE	538	543	6	LEFT/ALPHANUMERIC	NO	YES		
(69) PRINCIPAL DIAGNOSIS CODE	544	549	6	LEFT/ALPHANUMERIC	NO	YES	The condition which has been established to have been the chief cause of admission for care.	CP DENTAL FACILITIES DO NOT REPORT DIAGNOSES

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(70) ADMITTING DIAGNOSIS CODE	550	555	6	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL FACILITIES DO NOT REPORT DIAGNOSES
(71) EXTERNAL CAUSE CODE	556	561	6	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL FACILITIES DO NOT REPORT DIAGNOSES
(72) DISCHARGE DIAGNOSIS CODE	562	567	6	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL FACILITIES DO NOT REPORT DIAGNOSES
(73) UNIQUE DIAGNOSIS COUNTER	568	569	2	RIGHT/NUMERIC	YES	YES		DEFAULT "0", LEADING SPACE
(74) DIAGNOSIS CODE	570	575	6	LEFT/ALPHANUMERIC	NO	YES		CP DENTAL FACILITIES DO NOT REPORT DIAGNOSES
(75) PROCEDURE CODING METHOD PRINCIPAL	576	576	1	RIGHT/NUMERIC	NO	YES		
(76) PROCEDURE CODE PRINCIPAL	577	582	6	LEFT/ALPHANUMERIC	NO	YES	The procedure which was performed for definitive treatment rather than diagnostic or exploratory purposes, unless these were the only types of procedures rendered during the event.	
(77) PROCEDURE MODIFIER OR TOOTH PRINCIPAL	583	584	2	LEFT/ALPHANUMERIC	NO	YES		
(78) LINE ITEM COUNTER	585	585	1	RIGHT/NUMERIC	YES	YES		THIS COUNTER LISTS THE NUMBER OF LINE ITEMS
(79) TOOTH NUMBER - LINE 1	586	587	2	RIGHT/NUMERIC	YES	YES		
(80) CDS CODE - LINE 1	588	591	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(81) CHARGE AMOUNT - LINE 1	592	600	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(82) ALLOWED AMOUNT - LINE 1	601	609	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED
(83) PAID AMOUNT - LINE 1	610	618	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(84) SERVICE FROM DATE - LINE 1	619	626	8	DATE	YES	YES		FORMAT: MMDDCCYY
(85) SERVICE THRU DATE - LINE 1	627	634	8	DATE	YES	YES		FORMAT: MMDDCCYY
(86) REMARKS CODE - LINE 1	635	636	2	LEFT/ALPHANUMERIC	YES	YES		AIA CODE FOR STATUS OR REASON FOR DENIAL
(87) TOOTH NUMBER - LINE 2	637	638	2	RIGHT/NUMERIC	YES	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(88) CDS CODE - LINE 2	639	642	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(89) CHARGE AMOUNT - LINE 2	643	651	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(90) ALLOWED AMOUNT - LINE 2	652	660	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED
(91) PAID AMOUNT - LINE 2	661	669	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(92) SERVICE FROM DATE - LINE 2	670	677	8	DATE	YES	YES		FORMAT: MMDDCCYY
(93) SERVICE THRU DATE - LINE 2	678	685	8	DATE	YES	YES		FORMAT: MMDDCCYY
(94) REMARKS CODE - LINE 2	686	687	2	LEFT/ALPHANUMERIC	YES	YES		AIA CODE FOR STATUS OR REASON FOR DENIAL
(95) TOOTH NUMBER - LINE 3	688	689	2	RIGHT/NUMERIC	YES	YES		
(96) CDS CODE - LINE 3	690	693	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(97) CHARGE AMOUNT - LINE 3	694	702	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(98) ALLOWED AMOUNT - LINE 3	703	711	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED
(99) PAID AMOUNT - LINE 3	712	720	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(100) SERVICE FROM DATE - LINE 3	721	728	8	DATE	YES	YES		FORMAT: MMDDCCYY
(101) SERVICE THRU DATE - LINE 3	729	736	8	DATE	YES	YES		FORMAT: MMDDCCYY
(102) REMARKS CODE - LINE 3	737	738	2	LEFT/ALPHANUMERIC	YES	YES		AIA CODE FOR STATUS OR REASON FOR DENIAL
(103) TOOTH NUMBER - LINE 4	739	740	2	RIGHT/NUMERIC	YES	YES		
(104) CDS CODE - LINE 4	741	744	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(105) CHARGE AMOUNT - LINE 4	745	753	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(106) ALLOWED AMOUNT - LINE 4	754	762	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(107) PAID AMOUNT - LINE 4	763	771	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(108) SERVICE FROM DATE - LINE 4	772	779	8	DATE	YES	YES		FORMAT: MMDDCCYY
(109) SERVICE THRU DATE - LINE 4	780	787	8	DATE	YES	YES		FORMAT: MMDDCCYY
(110) REMARKS CODE - LINE 4	788	789	2	LEFT/ALPHANUMERIC	YES	YES		AIA CODE FOR STATUS OR REASON FOR DENIAL
(111) TOOTH NUMBER - LINE 5	790	791	2	RIGHT/NUMERIC	YES	YES		
(112) CDS CODE - LINE 5	792	795	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(113) CHARGE AMOUNT - LINE 5	796	804	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(114) ALLOWED AMOUNT - LINE 5	805	813	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED
(115) PAID AMOUNT - LINE 5	814	822	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(116) SERVICE FROM DATE - LINE 5	823	830	8	DATE	YES	YES		FORMAT: MMDDCCYY
(117) SERVICE THRU DATE - LINE 5	831	838	8	DATE	YES	YES		FORMAT: MMDDCCYY
(118) REMARKS CODE - LINE 5	839	840	2	LEFT/ALPHANUMERIC	YES	YES		AIA CODE FOR STATUS OR REASON FOR DENIAL
(119) TOOTH NUMBER - LINE 6	841	842	2	RIGHT/NUMERIC	YES	YES		
(120) CDS CODE - LINE 6	843	846	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(121) CHARGE AMOUNT - LINE 6	847	855	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(122) ALLOWED AMOUNT - LINE 6	856	864	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED
(123) PAID AMOUNT - LINE 6	865	873	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(124) SERVICE FROM DATE - LINE 6	874	881	8	DATE	YES	YES		FORMAT: MMDDCCYY
(125) SERVICE THRU DATE - LINE 6	882	889	8	DATE	YES	YES		FORMAT: MMDDCCYY
(126) REMARKS CODE - LINE 6	890	891	2	LEFT/ALPHANUMERIC	YES	YES		
(127) TOOTH NUMBER - LINE 7	892	893	2	RIGHT/NUMERIC	YES	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(128) CDS CODE - LINE 7	894	897	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(129) CHARGE AMOUNT - LINE 7	898	906	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(130) ALLOWED AMOUNT - LINE 7	907	915	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED
(131) PAID AMOUNT - LINE 7	916	924	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(132) SERVICE FROM DATE - LINE 7	925	932	8	DATE	YES	YES		FORMAT: MMDDCCYY
(133) SERVICE THRU DATE - LINE 7	933	940	8	DATE	YES	YES		FORMAT: MMDDCCYY
(134) REMARKS CODE - LINE 7	941	942	2	LEFT/ALPHANUMERIC	YES	YES		AIA CODE FOR STATUS OR REASON FOR DENIAL
(135) TOOTH NUMBER - LINE 8	943	944	2	RIGHT/NUMERIC	YES	YES		
(136) CDS CODE - LINE 8	945	948	4	RIGHT/NUMERIC	YES	YES		CALIFORNIA DENTAL SYSTEMS CODE - DESCRIBES THE SURFACE OF THE TOOTH (SIMILAR TO CPT CODE)
(137) CHARGE AMOUNT - LINE 8	949	957	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM CHARGE
(138) ALLOWED AMOUNT - LINE 8	958	966	9	LEFT/ALPHANUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM ALLOWED
(139) PAID AMOUNT - LINE 8	967	975	9	RIGHT/NUMERIC	YES	YES		(FORMAT 9.2, IMPLIED DECIMAL) LINE ITEM PAID
(140) SERVICE FROM DATE - LINE 8	976	983	8	DATE	YES	YES		FORMAT: MMDDCCYY
(141) SERVICE THRU DATE - LINE 8	984	991	8	DATE	YES	YES		FORMAT: MMDDCCYY
(142) REMARKS CODE - LINE 8	992	993	2	LEFT/ALPHANUMERIC	YES	YES		AIA CODE FOR STATUS OR REASON FOR DENIAL
(143) CANCELLATION DATE	994	1001	8	DATE	YES	YES		
(144) REFUND/CANCELLED	1002	1002	1	RIGHT/NUMERIC	YES	YES		VALUES ARE "R" FOR PARTIAL REFUND AND "C" CANCELLED CLAIM
(145) AIA POLICY NUMBER	1003	1012	10	LEFT/ALPHANUMERIC	YES	NO	AIA Policy Number is used to define the policy number for each CP program on the label of CD and data set file of claims submitted by AIA.	FORMAT: XXXNNN - AIA Policy Number per program is as follows: Dental ('PPD989')

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: DENTAL CLAIMS

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(146) FISCAL YEAR DATE	1013	1017	5	LEFT/ALPHANUMERIC	YES	NO	The Fiscal Year Date is used to identify the Fiscal Year the CP claim(s) were processed by AIA for each program policy.	FORMAT: YY-YY
(147) AIA CLAIM TYPE	1018	1018	1	LEFT/ALPHANUMERIC	YES	NO	The AIA Claim Type is used to identify the type of claim per visit by the patient for all CP programs.	VALUES "D" FOR DRUG
(148) AIA RECEIVED DATE	1019	1026	8	DATE	YES	NO	The AIA Received Date is used to identify the date AIA received the claim(s) data from the CP agencies.	FORMAT: MMDDCCYY
(149) SPA NUMBER	1027	1028	2	LEFT/ALPHANUMERIC	YES	?		CLINIC LOCATION
(150) SUPERVISORY NUMBER	1029	1030	2	LEFT/ALPHANUMERIC	YES	?		SUPERVISORY DISTRICT NUMBER
(151) CONTRACT NUMBER	1031	1037	7	LEFT/ALPHANUMERIC	YES	?		CLINIC CONTRACT NUMBER

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PHARMACY CLAIMS (Specialty and Dental)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(1) PATIENT LAST NAME	1	20	20	LEFT/ALPHANUMERIC	YES	NO	The full surname or family name of the patient.	
(2) PATIENT FIRST NAME	21	35	15	LEFT/ALPHANUMERIC	YES	NO	The full first or given name of the patient, minimally the first name initial.	
(3) PATIENT MIDDLE NAME	36	36	1	LEFT/ALPHANUMERIC	YES	YES	The full middle name of the patient when it is available.	ONLY MIDDLE INITIAL AVAILABLE
(4) DATE OF BIRTH	37	44	8	DATE	YES	NO	The month, day, century and year of a person's birth. Used to calculate age at the time of an event.	FORMAT: MMDDCCYY
(5) SEX	45	45	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate gender.	(2=Female, 1=Male, 0=Unknown)
(6) RACE/ETHNICITY	46	46	1	LEFT/ALPHANUMERIC	YES	NO	The code used to designate race or ethnicity.	
(7) PATIENT MARITAL STATUS	47	47	1	LEFT/ALPHANUMERIC	YES	YES		
(8) PRIMARY LANGUAGE CODE	48	49	2	LEFT/ALPHANUMERIC	YES	NO		
(9) MOTHER MAIDEN NAME	50	69	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the mother of the patient.	
(10) MOTHER FIRST NAME	70	84	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the mother of the patient.	
(11) FATHER LAST NAME	85	104	20	LEFT/ALPHANUMERIC	NO	YES	The surname or family name of the father of the patient.	
(12) FATHER FIRST NAME	105	119	15	LEFT/ALPHANUMERIC	NO	YES	The full first name or initial of the father of the patient.	
(13) PATIENT ADDRESS	120	154	35	LEFT/ALPHANUMERIC	YES	NO	The street number and street name, including street direction and apt. designation, of usual or permanent address.	
(14) PATIENT CITY	155	174	20	LEFT/ALPHANUMERIC	YES	NO	The name of the city or town where the patient resides.	
(15) PATIENT STATE	175	176	2	LEFT/ALPHANUMERIC	YES	NO	The name of the state where the patient resides.	
(16) PATIENT ZIP CODE	177	181	5	LEFT/ALPHANUMERIC	YES	NO	Zip code of patient's usual or permanent address.	WHEN PATIENT ZIP CODE = '99999' THEN PATIENT ADDRESS IS NOT KNOWN PER AIA.

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PHARMACY CLAIMS (Specialty and Dental)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(17) PATIENT BIRTHPLACE	183	201	20	LEFT/ALPHANUMERIC	NO	YES	The name of city, town, village, state, and/or country the patient was born.	
(18) FAMILY SIZE	202	203	2	RIGHT/NUMERIC	YES	YES	Based on ATP faimily size definition.	DEFAULT SET TO ZERO
(19) MONTHLY INCOME	204	210	7	RIGHT/NUMERIC	NO	YES	The total monthly income received for the previous month by all related family members residing with patient(s).	
(20) SOURCE OF INCOME	211	211	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the primary or largest single source of family income.	
(21) TYPE OF EMPLOYMENT	212	212	1	LEFT/ALPHANUMERIC	NO	YES	The code used to designate the occupation of the patient's family primary wage earner.	
(22) COUNTY ID	213	221	9	LEFT/ALPHANUMERIC	YES	NO		CHANGED AS OF 8-20-03 FROM ADMITTING
(23) PATIENT ACCOUNT NUMBER	222	231	10	LEFT/ALPHANUMERIC	YES	NO	Patient account number is generated and assigned by an individual CP program contractor for each submitted claim. It is the internal medical record number of an identified CP program provider.	
(24) SOCIAL SECURITY NUMBER	232	240	9	LEFT/ALPHANUMERIC	YES	NO	The patient's social security number.	
(25) CLAIM NUMBER	241	244	4	LEFT/ALPHANUMERIC	YES	NO	Claim number is generated and assigned by AIA for each claim submitted. The claim number sequence is patient specific. A patient can potentially have 9,999 claims submitted per fiscal year.	NTH NUMBER OF CLAIM(S) PER PATIENT

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PHARMACY CLAIMS (Specialty and Dental)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(26) MEDI-CAL IDENTIFICATION NUMBER	245	259	15	LEFT/ALPHANUMERIC	NO	YES	The Medi-Cal identifier issued by the State of California to the patient receiving medical services.	DENIED AND CANCELLED CLAIMS ARE NOT SEND TO DHS
(27) RECORD TYPE	260	260	1	LEFT/ALPHANUMERIC	YES	YES		DEFAULT VALUE IS 'D', DRUG
(28) PRIMARY VISIT DATE	261	268	8	DATE	YES	YES		FORMAT: MMDDCCYY
(29) BILLING FROM DATE	269	276	8	DATE	YES	NO		TOGETHER WITH BILLING THRU DATE, EQUALS THE TOTAL RANGE OF SERVICE FROM AND SERVICE THRU
(30) BILLING THRU DATE	277	284	8	DATE	YES	YES		TOGETHER WITH BILLING FROM DATE, EQUALS THE TOTAL RANGE OF SERVICE FROM AND SERVICE THRU
(31) REMITTANCE ADVISE DATE	285	292	8	DATE	YES	YES		FORMAT: MMDDCCYY
(32) TOTAL AMOUNT BILLED	293	299	7	RIGHT/NUMERIC	YES	YES		
(33) TOTAL ALLOWABLE AMOUNT	300	306	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(34) TOTAL AMOUNT PAID	307	313	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(35) OVERRIDE 45 DAYS CODE	314	314	1	LEFT/ALPHANUMERIC	YES	YES		Y' OR 'N'
(36) FACILITY ID	315	323	9	LEFT/ALPHANUMERIC	YES	NO		AIA SENDS THE FACILITIES' TAX ID. THEY STATED THAT THEY DISTINGUISH MULTIPLE FACILITIES WITH SAME TAX ID BY A SUFFIX, WHICH HAS BEEN ADDED
(37) FACILITY ID SUFFIX	324	324	1	LEFT/ALPHANUMERIC	YES	NO		AIA USES A ONE-CHARACTER ALPHA VALUE
(38) RECORD SOURCE	325	326	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate the source code for each feeder system (Sub-Project).	DEFAULT '21' FOR P/PP DENTAL, '19' FOR P/PP PRIMARY, '20' FOR P/PP SPECIALTY, '22' FOR P/PP PHARMACY, '30' FOR P/PP GR
(39) SERVICE SETTING CODE	327	328	2	LEFT/ALPHANUMERIC	YES	YES	The code used to designate a provider service setting.	DEFAULT TO '3'
(40) LINE ITEM COUNTER	329	329	1	RIGHT/NUMERIC	YES	YES		THIS COUNTER LISTS THE NUMBER OF LINE ITEMS. MAXIMUM VALUE
(41) LINE ITEM NUMBER 1	330	330	1	RIGHT/NUMERIC	YES	YES		
(42) PRESCRIPTION NUMBER	331	338	8	LEFT/ALPHANUMERIC	YES	YES		
(43) DATE OF SERVICE	339	346	8	DATE	YES	YES		FORMAT: MMDDCCYY
(44) QUANTITY	347	352	6	RIGHT/NUMERIC	YES	YES		
(45) DAYS SUPPLY	353	355	3	RIGHT/NUMERIC	YES	YES		
(46) NDC NUMBER	356	366	11	RIGHT/NUMERIC	YES	YES		
(47) NDC DESCRIPTION	367	396	30	LEFT/ALPHANUMERIC	YES	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PHARMACY CLAIMS (Specialty and Dental)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(48) LINE CHARGE	397	403	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(49) LINE ALLOWED	404	410	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(50) LINE PAID	411	417	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(51) CODE 1 RESTRICTION MET	418	418	1	LEFT/ALPHANUMERIC	YES	YES		REFILL INDICATIOR, VALUE = 'Y' OR 'N'
(52) REMARK CODE	419	421	3	LEFT/ALPHANUMERIC	YES	YES		
(53) REMARK DESCRIPTION	422	451	30	LEFT/ALPHANUMERIC	YES	YES		
(54) LINE ITEM NUMBER 2	452	452	1	RIGHT/NUMERIC	YES	YES		
(55) PRESCRIPTION NUMBER	453	460	8	LEFT/ALPHANUMERIC	YES	YES		
(56) DATE OF SERVICE	461	468	8	DATE	YES	YES		FORMAT: MMDDCCYY
(57) QUANTITY	469	474	6	RIGHT/NUMERIC	YES	YES		
(58) DAYS SUPPLY	475	477	3	RIGHT/NUMERIC	YES	YES		
(59) NDC NUMBER	478	488	11	RIGHT/NUMERIC	YES	YES		
(60) NDC DESCRIPTION	489	518	30	LEFT/ALPHANUMERIC	YES	YES		
(61) LINE CHARGE	519	525	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(62) LINE ALLOWED	526	532	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(63) LINE PAID	533	539	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(64) CODE 1 RESTRICTION MET	540	540	1	LEFT/ALPHANUMERIC	YES	YES		REFILL INDICATIOR, VALUE = 'Y' OR 'N'
(65) REMARK CODE	541	543	3	LEFT/ALPHANUMERIC	YES	YES		
(66) REMARK DESCRIPTION	544	573	30	LEFT/ALPHANUMERIC	YES	YES		
(67) LINE ITEM NUMBER 3	574	574	1	RIGHT/NUMERIC	YES	YES		
(68) PRESCRIPTION NUMBER	575	582	8	LEFT/ALPHANUMERIC	YES	YES		
(69) DATE OF SERVICE	583	590	8	DATE	YES	YES		FORMAT: MMDDCCYY
(70) QUANTITY	591	596	6	RIGHT/NUMERIC	YES	YES		
(71) DAYS SUPPLY	597	599	3	RIGHT/NUMERIC	YES	YES		
(72) NDC NUMBER	600	610	11	RIGHT/NUMERIC	YES	YES		
(73) NDC DESCRIPTION	611	640	30	LEFT/ALPHANUMERIC	YES	YES		
(74) LINE CHARGE	641	647	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(75) LINE ALLOWED	648	654	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(76) LINE PAID	655	661	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(77) CODE 1 RESTRICTION MET	662	662	1	LEFT/ALPHANUMERIC	YES	YES		REFILL INDICATIOR, VALUE = 'Y' OR 'N'
(78) REMARK CODE	663	665	3	LEFT/ALPHANUMERIC	YES	YES		
(79) REMARK DESCRIPTION	666	695	30	LEFT/ALPHANUMERIC	YES	YES		

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PHARMACY CLAIMS (Specialty and Dental)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(80) LINE ITEM NUMBER 4	696	696	1	RIGHT/NUMERIC	YES	YES		
(81) PRESCRIPTION NUMBER	697	704	8	LEFT/ALPHANUMERIC	YES	YES		
(82) DATE OF SERVICE	705	712	8	DATE	YES	YES		FORMAT: MMDDCCYY
(83) QUANTITY	713	718	6	RIGHT/NUMERIC	YES	YES		
(84) DAYS SUPPLY	719	721	3	RIGHT/NUMERIC	YES	YES		
(85) NDC NUMBER	722	732	11	RIGHT/NUMERIC	YES	YES		
(86) NDC DESCRIPTION	733	762	30	LEFT/ALPHANUMERIC	YES	YES		
(87) LINE CHARGE	763	769	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(88) LINE ALLOWED	770	776	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(89) LINE PAID	777	783	7	RIGHT/NUMERIC	YES	YES		2 DECIMAL POSITIONS
(90) CODE 1 RESTRICTION MET	784	784	1	LEFT/ALPHANUMERIC	YES	YES		REFILL INDICATOR, VALUE = 'Y' OR 'N'
(91) REMARK CODE	785	787	3	LEFT/ALPHANUMERIC	YES	YES		
(92) REMARK DESCRIPTION	788	817	30	LEFT/ALPHANUMERIC	YES	YES		
(93) CANCELLATION DATE	818	825	8	DATE	YES	YES		
(94) REFUND/CANCELLED	826	826	1	RIGHT/NUMERIC	YES	YES		VALUES ARE "R" FOR PARTIAL REFUND AND "C" CANCELLED CLAIM
(95) FUND CODE	827	827	1	LEFT/ALPHANUMERIC	YES	NO	A code used to define the program a patient is enrolled in and monies processed.	SPECIALTY RX VALUE = 'S' AND DENTAL RX VALUE = 'P'
(96) AIA POLICY NUMBER	828	837	10	LEFT/ALPHANUMERIC	YES	NO	AIA Policy Number is used to define the policy number for each CP program on the label of CD and data set file of claims submitted by AIA.	FORMAT: XXXNNN - AIA Policy Number per program is as follows: Specialty RX ('PPS089', 'PPS090', 'PPS101', 'PPS112', etc); and Dental RX ('PPD989')
(97) FISCAL YEAR DATE	838	842	5	LEFT/ALPHANUMERIC	YES	NO	The Fiscal Year Date is used to identify the Fiscal Year the CP claim(s) were processed by AIA for each program policy.	FORMAT: YY-YY
(98) AIA CLAIM TYPE	843	843	1	LEFT/ALPHANUMERIC	YES	NO	The AIA Claim Type is used to identify the type of claim per visit by the patient for all CP programs.	VALUES ARE "P" FOR PPP, "A" FOR ANCILLARY, "D" FOR DRUG, "R" FOR SPECIALTY RX

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

Data Layout

Record Set: PHARMACY CLAIMS (Specialty and Dental)

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	NULL	FIELD DESCRIPTION	COMMENT
(99) AIA RECEIVED DATE	844	851	8	DATE	YES	NO	The AIA Received Date is used to identify the date AIA received the claim(s) data from the CP agencies.	FORMAT: MMDDCCYY
(100) SPA NUMBER	852	853	2	LEFT/ALPHANUMERIC	YES	?		CLINIC LOCATION
(101) SUPERVISORY NUMBER	854	855	2	LEFT/ALPHANUMERIC	YES	?		SUPERVISORY DISTRICT NUMBER
(102) PRESCRIBER'S NAME	856	875	20	LEFT/ALPHANUMERIC	YES	?		NAME OF PRESCRIBING DOCTOR
(103) PRESCRIBER'S NPI	876	885	10	LEFT/ALPHANUMERIC	YES	?		
(104) AUTHORIZATION NUMBER	886	895	10	LEFT/ALPHANUMERIC	YES	?		CERTAIN NDCs ON LA COUNTY'S FORMULARY REQUIRES AUTHORIZATION
(105) CONTRACT NUMBER	896	902	7	LEFT/ALPHANUMERIC	YES	?		CLINIC CONTRACT NUMBER
(106) MANUAL/ELECTRONIC	903	903	1	LEFT/ALPHANUMERIC	YES	YES		DEFAULT VALUES ARE 'M' OR 'E'

ATTACHMENT B-6

DATA CODE TABLE

TABLE NAME	CODE	
CITY CODE	Attach to a separate table (LACounty city codes).	
CLINIC CODE	Attach to a separate CLNIC code table.	
CPT	Attach to separate CPT CODE table (code file has 7.146 records).	
ER DISPOSITION	0	NOT APPLICABLE
	1	RELEASE
	2	TRANSFER TO ANOTHER HOSPITAL
	3	ADMISSION
	4	DEATH
ER FLAG	0	NOT AN EMERGENCY VISIT
	1	ER/NON-EMERGENCY VISIT
	2	ER/EMERGENCY VISIT
HIV	0	Non-HIV positive or undetermined
	1	HIV positive
ICD	Attach to separate ICD CODE table.	
OUTPATIENT SERVICES	0	UNKNOWN
	1	PRIMARY CARE
	2	SPECIALTY CARE
	3	HOME HEALTH CARE
	4	DENTAL CARE
	5	LABORATORY
	6	MEDICAL SUPPLIES
	7	OPTOMETRY
	8	PHARMACY
	9	PODIATRY
	10	DETOXIFICATION
	11	RADIOLOGY
	12	AMBULATORY SURGERY
	13	OTHER (RESIDENCY)

ATTACHMENT B-6

DATA CODE TABLE

TABLE NAME	CODE	
PAYER SUMMARY	Attach to a separate table.	
PROVIDER RELATIONSHIP	0	UNKNOWN
	1	COUNTY HOSPITAL
	2	CONTRACT HOSPITAL
	3	UNIVERSITY TEACHING HOSPITAL
	4	OTHER NON-CONTRACT HOSPITAL
PROVIDER SUMMARY	Attach to a separate table.	
RACE/ETHNICITY	0	UNKNOWN
	1	WHITE
	3	BLACK
	5	HISPANIC/SPANISH SURNAME
	6	NATIVE AMERICAN/ESKIMO/ALEUT
	7	ASIAN/PACIFIC ISLANDERS
	8	FILIPINO
	9	OTHER
	0	UNKNOWN
REC-SOURCE	1	Non-County Hospitals (EMS – CRSIS) [Discretionary]
	2	County Hospitals
	3	Non-County Hospitals (EMS – LANCET) [Discretionary]
	4	Non-County Physicians (CPO) [Discretionary]
	5	HCOIS (PHP&S and West Hollywood Clinic)
	6	PHP&S (Compucare)
	7	AIDS Program Office (APO)
	9	Non-County Physicians (CPO) [Non-Discretionary]
	10	Non-County Hospitals (EMS – CRSIS) [Non-Discretionary)
	11	Non-County Hospitals (EMS – LANCET) [Non-Discretionary)
	12	PHP&S (Health Centers/Utilization Data)
REFERRAL CODE	Attach to separate REFERRAL CODE file.	

ATTACHMENT B-6

DATA CODE TABLE

TABLE NAME	CODE	
SERVICE EVENTS	0	UNKNOWN
	1	ADMISSION
	2	DISCHARGE
	3	TRANSFER IN
	4	TRANFER OUT
	5	DEATH
	6	BIRTH
	7	RELEASE
	8	VISIT
SERVICE SETTINGS	0	UNKNOWN
	1	HOSPITAL INPATIENT
	2	HOSPITAL EMERGENCY ROOM
	3	HOSPITAL OUTPATIENT
	4	COMPREHENSIVE HEALTH CENTER
	5	HEALTH CENTER
	6	FREE STANDING CLINIC
	7	PHYSICIAN OFFICE
	8	INPATIENT MENTAL HEALTH
	9	INPATIENT REHABILITATION
	10	SKILLED NURSING FACILITY
	11	INTERMEDIATE CARE FACILITY
	12	AMBULANCE
	13	HOME HEALTH CARE
	14	DENTAL
	15	RESIDENTIAL
SERVICE UNITS	0	NOT APPLICABLE
	1	DAY
	2	VISIT
	3	TEST
	4	IMAGE
	5	PRESCRIPTION
	6	SESSION
	7	EPISODE
	8	HOUR
	9	CASE EVALUATION
	10	DURABLE MEDICAL SUPPLES

ATTACHMENT B-6

DATA CODE TABLE

TABLE NAME	CODE	
SEX	0	UNKNOWN
	1	MALE
	2	FEMALE
SOURCE OF INCOME	0	UNKNOWN
	1	SELF EMPLOYED
	2	DISABILITY
	3	RETIREMENT
	4	PUBLIC ASSISTANCE
	5	OTHER e.g. V. A. benefits, interest, dividends, rent, child support, attorney, etc.
	6	WAGES
	9	NONE
SOURCE OF PAYMENT	0	UNKNOWN
	1	SELF-PAY
	2	PRIVATE INSURANCE
	3	MEDICARE
	4	MEDI-CAL
	5	CHIP/RHS
	6	MISP
	7	OTHER SECTION 17000
	8	OTHER/DONATION
STATUS-CODE	1	PRIMARY (Principal)
	2	OTHER
TYPE OF EMPLOYMENT	0	UNKNOWN
	1	FARMING, FORESTRY, FISHING
	2	PRODUCTION, INSPECTION, REPAIR, CRAFT, HANDLERS, HELPERS, LABORERS, TRANSPORTATION
	3	SERVICES, SALES
	4	EXECUTIVE, ADMINISTRATIVE, MANAGERIAL, PROFESSIONAL, TECHNICAL AND RELATED SUPPORT
	5	OTHER
	6	UNEMPLOYED

PROVIDER PROFILE

#	FIELD NAME	DESCRIPTION
1	PROVIDER NAME	Name of Clinic
2	PROVIDER STREET	Clinic's Address
3	PROVIDER CITY	Clinic's City
4	PROVIDER STATE	Clinic's State
5	PROVIDER ZIP	Clinic's Zip Code
6	PROVIDER PHONE NUMBER	Clinic's Phone Number
7	BEGIN DATE OF CONTRACT	Begin date when the clinic was contracted/approved to perform services.
8	END DATE OF CONTRACT	Date when clinic stopped providing services
9	PROVIDER CONTACT NAME	Name of person who can be contacted and be responsible for responding to questions/issues should they arise.
10	PROVIDER CONTACT PHONE NUMBER	Phone number of contract person.

EXHIBIT C

SERVICES FOR THE METROCARE PHYSICIAN PROGRAM (MPP)
CLAIMS ADJUDICATION SERVICES
STATEMENT OF WORK

1. Definitions:

A. Eligible Hospitals: The MetroCare Physician Program (MPP) covers the provision of eligible physician services to eligible indigent patients at designated hospitals under the following County contracts:

a) Impacted Hospitals Program

California Hospital Medical Center

Centinela Freeman Regional Medical Center

Downey Regional Medical Center

Lakewood Regional Medical Center

Long Beach Memorial Medical Center

Memorial Hospital of Gardena

Saint Francis Medical Center

White Memorial Medical Center

b) MetroCare Program

Saint Vincent Medical Center

c) Transitional Capacity Allowance

Saint Francis Medical Center

The eligible hospitals for the MetroCare Physician Program will be added or removed by the County due to future changes to the contracts with the hospitals.

B. Claims Adjudication Services: Claims adjudication services for the MetroCare Physician Program include receipt, review, Medi-Cal/Medicare/Other insurance coverage identification, MPP eligibility determination, and provision of preliminary payment listings and final payment information in electronic formats for MPP claims submitted by physicians for eligible medical services rendered to eligible indigent patients. These services shall be provided according to MPP policies, procedures, and instructions, which are subject to revision from time to time. For purposes of this Agreement, a claim includes a Centers for Medicare and Medicaid Services ("CMS-1500) Form (formerly known as a Health Care Financing Administration "HCFA 1500" Form), Attachment C-1, and will include a Medical Alert Center (MAC) transfer authorization number, (Box 11 of CMS 1500 Form), or as otherwise identified as a MPP claim, or other forms that may be approved and required by the Director.

C. Adjudicated: As used herein, the term "adjudicated" shall apply to claims for which all claims

adjudication services have been completed, according to the MPP policies and procedures, and a payment request or denial has been issued.

D. Denied: As used herein, the term "denied" shall mean a claim or medical procedure that has been adjudicated according to program policies and procedures and found not to be payable.

E. Electronic Claim: As used herein, the term "electronic claim" shall mean a claim that is submitted to the Contractor on a disk, or other form of computer media by MPP physicians for reimbursement of eligible medical services rendered to eligible indigent patients.

F. Fiscal Year ("FY"): As used herein, the term "fiscal year" shall mean the twelve (12) month period beginning July 1st of a year and ending June 30th of the following year.

G. Hard-Copy Claim: As used herein, the term "hard-copy claim" shall mean a claim that is submitted to Contractor on paper (hard copy CMS 1500 Form) by MetroCare physicians for reimbursement of eligible medical services rendered to eligible indigent patients .

H. On-line Access: As used herein, the term "on-line access" shall mean the electronic linkage of

Contractor's computerized claims adjudication system to County personal computers (PCs) located at County specified sites (minimum of two (2)) which permit County access to the MetroCare Physician Profile Database ("PPD") and MPP Database.

I. Administrative Appeal: As used herein, the term "Administrative Appeal" shall mean an appeal which 1) involves an issue exclusively related to the MPP policies and procedures; and 2) does not involve medical issues.

J. Medical Appeal: As used herein, the term "Medical Appeal" shall mean an appeal which involves a medical issue exclusively, and requires the expertise of an appropriate medical professional for appeal resolution.

K. Contractor’s System: As used herein, the term "Contractor’s System" shall mean any and all computer systems/resources used by Contractor to perform claims adjudication, reporting, etc.

2. Contractor Personnel:

A. Contractor shall designate a Project Manager to lead and coordinate Contractor's claims adjudication services hereunder.

B. Notwithstanding any representation by County regarding the participation of County personnel in any

phase of this project, Contractor assumes sole responsibility for the timely accomplishment of all activities described herein.

3. County Personnel: Chief, Fiscal Services, Department of Health Services, shall be designated as County Project Manager (CPM) for activities hereunder, unless otherwise determined by Director. County personnel will be made available to Contractor at the sole-discretion of CPM to provide necessary input and assistance in order to answer questions and provide necessary liaison activities between Contractor and County departments. The word "County" or "Director" shall be deemed to refer to the CPM.

4. Services to Be Provided: Services to be provided immediately upon Board of Supervisors approval include, but shall not be limited to:

A. Contractor shall process hard-copy and electronic claims using an on-line claims processing system and line-item and/or on-line adjudication.

B. Contractor's claims review and processing procedures must include, but shall not be limited to, the following:

1) Sorting claims.

2) Date stamping (i.e., Month/Date/Year) all claims upon receipt, at the time of the original submission and any subsequent resubmission(s).

3) Reviewing claims for completeness and accuracy based on the MPP billing instructions provided by County.

4) Rejecting and returning claims which are incomplete or inaccurate and return to the submitting physician within twelve (12) working days of claim receipt, with a Director approved letter stating the claim deficiencies and the procedures for resubmission, or as otherwise agreed to by Director and Contractor.

5) Entering the contract hospital code.

6) Entering the service setting as emergency, inpatient, and limited outpatient [one {1) follow-up visit] medical services through acute hospitalization and one (1) outpatient visit authorized by the County, reason for rejection, claim receipt date, physician’s name, tax identification number (“ID#”), patient’s name, date of service, and service location on Contractor’s system.

7) Entering all claim information and all data elements (Attachments C-2 to C-5) into the Contractor’s system for all complete claims.

8) Flagging all incomplete, erroneous, and duplicate claims.

9) Reflecting line-item denials.

10) Validating procedure and diagnosis codes.

11) Denying claims covered by insurance.

12) Identifying and adjudicating eligible claims by the earliest of the following dates: (a) Twenty (20) working days after the the Trauma Capacity Allowance (TCA) – Saint Francis Medical Center data match, by comparing the claims with the TCA hospital patient data file provided to Contractor by County’s Emergency Medical Services Agency (EMS); (b) Twenty (20) working days after the MetroCare – Saint Vincent Medical Center (SVMC) data match, by comparing the claims with the SVMC hospital patient data file provided to Contractor by County’s EMS; (c) Twenty (20) working days after the Impacted Hospital Program (IHP) data match, by comparing the claims with the IHP hospital patient data file provided to Contractor by County’s Health Services Department – Fiscal Services

(FS) and verified by FS if required; (d) Twenty (20) working days after verification by County’s FS, for eligible physician services rendered at eligible hospitals or facilities that should be adjudicated though not matching the TCA, SVMC and IHP hospital patient data files.

13) Automatically/manually assigning a unique claim number.

14) Performing audits and quality assurance sampling.

15) Providing claims reporting.

16) Performing other claim edits, as may be required by Director, from time to time.

17) Accepting amounts from the Director to be paid for each claim type, fund, and organization code, and being able to suspend any unprocessed claims which are not to be paid in the current payment cycle, and include any suspended claims in the next payment cycle in the order of the date received .

18) Preparing Remittance Advices ("RA"), pursuant to Attachment C-8 "Sample Remittance Advice Specifications", for claims adjudicated for payment and those denied due to Medi-Cal/Medicare coverage,

including the applicable Medi-Cal/Medicare numbers, and electronically transmitting via email the RAs on a bi-weekly basis to County site.

19) Slowing or ceasing claims adjudication services, upon Director's request, in order not to exceed MPP funding limits.

20) Providing an electronic warrant file to County's Auditor Controller, which will group the claims by funds, including an electronic copy of the warrant register.

21) Processing an updated copy of the electronic warrant file, including the issue date and warrant number provided by the County, on the same day if received by no later than 10:00 a.m., and by the next business day if not, using high speed, secure electronic media, as specified and agreed to by Director, to transmit and receive the electronic warrant files and add them to the RA before it is printed.

22) Providing physical and/or electronic mailing services, i.e, addressing, stuffing, sealing, scanning and attaching documents and mailing RAs, including the RAs for denied claims, to MetroCare physicians

(County will reimburse Contractor $0.015 per claim for handling fee and the additional postage costs associated with the physical mailing). On the same day of mailing, Contractor shall electronically transmit, via email, the RA report to DHS Fiscal Services.

23) Making all applicable MetroCare Fee Schedule modifications, per hospital contract, to its claims adjudication programs necessary to process and adjudicate all MPP claims and comply with this Exhibit, the Attachments, and modifications thereto, at no additional cost to County.

24) Recouping funds or reducing a physician's future claim payments (e.g., if the claim has been erroneously paid or if the physician receives a payment from the patient or third-party payor, after the claim has been paid), as instructed by Director, via a Director approved letter with recoupment payments to be sent directly to County along with a copy of the RA to County, or if the RA is not available, advising physicians to provide the following information along with the refund check:

- patient's name,

- AIA claim number,
- date of service,
- amount of patient's refund,
- physician's tax ID number, and
- physician's license number;
- adjusting the physician account balances accordingly when a refund is received and,
- at Director’s discretion, providing the Director or his designee(s) with access to Contractor’s system to either cancel claim in full or indicate partial refund adjustment.

C. Establish and maintain a unique PPD Database and MPP Database for each fiscal year (FY).

1) The PPD shall incorporate all data elements described in Attachment C-9, Contract Physician Profile Record Layout. Contractor shall regularly update the PPD to ensure that physician information, as requested on the Physician Enrollment Form, is readily available to Director. The PPD shall be based on Attachment C-3, Physician Enrollment Form and Attachment C-2, Conditions of Participation Agreement, which each participating physician submits upon entry

into MPP and updates each FY or more often as necessary. The Physician Enrollment Form shall serve as written notice from the physician that information may be entered into the Database.

2) The MPP Database incorporates all data elements necessary for all MPP related work, including, but not limited to, preparing reports and providing data as described within this Agreement and related Attachments.

D. Provide electronic data for storage in County information repository on a monthly basis according to County specifications, as specified in the following Attachments:

- C-10: AIA Data Statement of Work
- C-11: AIA Record Layout/Dictionary

E. Review, analyze, and research all Administrative Appeal issues and recommend County action based on MPP policies and procedures. Contractor shall regularly attend scheduled meetings of the County's Physician Reimbursement Advisory Committee ("PRAC"). Upon Director’s approval, Contractor shall refer all Medical Appeals to the Physician Appeals Board. Contractor shall prepare appeal summaries and notifications to physicians of appeal disposition.

Responses to claim appeals shall be issued by Contractor with a Director approved letter, stating the appeal disposition and an updated RA, if appropriate. All claim appeal response letters are to be approved by Director and mailed by Contractor.

F. Provide system connectivity to two (2) County specified work stations to be designated by County's Project Manager. Contractor shall also provide the capability for County's personal computers, linked to Contractor's system, to have inquiry and view capability of data and records. County can, at the election of the Director and not affecting Contractor’s system and data security, request manipulation and modification of any and all data elements and/or data structures in the PSIP Database and PPD for data input/output and downloads as an ASCII, comma delimited, or Microsoft Excel or Access file, with the results and/or summary of such manipulation onto County's computers or a common storage device agreed by the County. If requested by Director, Contractor shall provide three (3) days of formal training for County on-line users and assistance as necessary for each year during the term of the Agreement. Director shall select the two (2) persons for which training will be provided.

G. Develop, maintain, and provide detailed written instructions for physician submission of claims, including electronic, as approved by Director. As needed or requested by Director, Contractor shall have workshops for County staff, physicians, and physician billing groups to support claim submission, both electronic and manual.

H. Provide and manage a telephone hot line for physicians to inquire on the status of claims. Questions regarding the MetroCare program or policy issues are to be referred to Director. Upon physician request, Contractor will send out the Director’s approved billing instructions. The hot line must be staffed from 8:00 a.m. to 4:30 p.m., Pacific Standard Time, Monday through Friday, except County holidays. At a minimum, the hot line must have voice mail or other message capabilities to receive calls during non-operation hours. Except for holidays and weekends, calls must be returned within 24 hours. A log of all calls must be maintained and shall include, but shall not be limited to:

- physician's name,
- billing group name,
- caller's name,
- claim number,

- date and time of call,
- a brief summary of the purpose and disposition of the call, and
- name of person who took the call.

This log shall be made available to Director upon request at all reasonable times, for review and for photocopying.

I. Prepare written materials for review and approval by Director prior to distribution (addressing, stuffing, and sealing envelopes) to physicians and deliver same to Director.

J. Develop and maintain a Backup System consisting of an electronic copy of the MPP Database, PPD, and all other related data on CD or on other County specified computer media off-site. The MPP Database shall be backed up on a daily basis; the PPD shall be backed up regularly. In the event that Contractor's system becomes inoperative, Director and Contractor shall mutually agree on a reasonable time frame to resume processing physician claims.

K. Provide Online Access to all active FY physician claims until year-end reconciliation has been completed and determined closed by County.

5. Additional Requirements: In performing the services hereinabove, Contractor shall:

A. Perform at all times in a professional and businesslike manner when assisting physicians and answering physician's questions.

B. Employ industry standards to ensure appropriate payments to physicians under the MetroCare program.

C. Respect the confidential nature of all information with regard to physician patient records and MPP financial records. Contractor acknowledges the confidentiality of all physician patient data and, therefore, shall obtain/extract only that information needed to meet claims processing and adjudication requirements. All such collected information shall become the property of County upon the termination of this Agreement, unless otherwise agreed to by Director.

D. Prepare all correspondence to physicians in a professional and businesslike manner; no correspondence may be hand written and all correspondence to physicians must be approved by Director in writing prior to sending, unless otherwise directed by County's Project Manager.

6. Optional Services: The County may exercise its option to require the Contractor to perform specific optional services.

County may require the Contractor to provide Medicare/Medi-Cal eligibility matching services, and/or the services of an Audit Nurse Specialist, who will work with County staff to ensure the medical codes listed on the claims are appropriate, no more than two 8-hour days per month. The nurse will be required to have knowledge of medical and financial coding.

7. Access to information: In order for Contractor to provide the services described in this Exhibit, Director shall provide Contractor necessary and pertinent MPP information, including operational/administrative records, and statistics.

Contractor shall return all the material provided by Director, upon his/her request, including but not limited to, MPP Database data files, PPD data files, physician patient records/data, MPP financial records, all information incidental to contract administration, all completed work, all MPP data, in the same condition and sequence in which received within thirty (30) calendar days from date of request.

8. Reports: Contractor shall provide financial, management, and ad-hoc reports, as requested by CPM. Contractor shall submit a weekly report listing all claims received in-house, and claims denied, rejected, Medi-Cal covered, and adjudicated by FY of service, as requested by CPM. Claim

management reports shall be submitted to CPM and shall include, but not be limited to, the following:

- Monthly reports with amounts of various payment categories and a monthly report that reflects weekly claim activity;
- Claims submitted and paid by individual physicians;
- Summary Reports (type/payment/status of claim);
- Claims by month or services or payment;
- Claims by physician tax ID#;
- Claims by physician license number;
- Claims reporting by procedure, diagnosis, and physician specialty by tax ID# and license number;
- Statistics and special reporting;
- RA Reports; and
- Ad-hoc reports, such as top 100 surgical codes, top 100 procedure codes, reports by physician specialty, and reports by hospital code to be provided within five (5) working days of written request.

The monthly report shall include weekly claim activity and shall reflect the number of rejected, denied, denied due to Medi-Cal/Medicare coverage, and adjudicated claims, as well as number of claims received in-house but which have not been processed and/or adjudicated. As each month of claims

processing services is completed, the monthly report describing that month's claim activity is to be submitted to Director within ten (10) working days of the end of that completed month. Contractor shall provide analysis and interpretation of reports, as needed.

Contractor shall prepare all the necessary reconciliation reports (monthly, quarterly, biannually, yearly, or as otherwise requested by Director) for each FY and make any and all necessary payment and/or refund adjustments. Contractor shall re-adjudicate MPP claims (due to changes in reimbursement rates by a percentage to be determined), as may be deemed necessary by CPM, and County shall pay for re-adjudicating the claims. If at any time re-adjudication is necessary due to an error of the contractor, then no additional per-claim costs shall be charged or billed by Contractor.

Director and Contractor shall mutually work to ensure that County's records and Contractor's MPP database are fully reconciled. Each FY shall be fully and completely reconciled as determined by Director.

9. Records and Audits: Subject to the conditions and terms set forth in the body of Agreement, Contractor agrees to make all billing and eligibility records available upon request, during normal business hours, to Director and authorized State

and federal representatives, for inspection, audit, and copying. Contractor may use CD or other media for purposes of maintaining hard copy claim files. Contractor shall provide to Director such material in County specified electronic data format and on specified computer media.

Such records shall be retained in accordance with the RECORDS AND AUDITS Paragraph of the ADDITIONAL PROVISIONS.

10. Quality Improvement: Contractor shall provide to Director a written description of the quality control and claim management procedures employed by Contractor to process and adjudicate MPP claims.

Quality control and claim management procedures shall include, but are not limited to, appropriate claim edits to ensure payment accuracy, non-payment of out-of-County claims, eligibility validation, flagging of duplicate billings and overpayments which require Contractor to recoup funds or to reduce a physician's future claim payments, and audit trails to substantiate all adjudicated claim payment authorizations.

Director may periodically sample Contractor's work and request Contractor to provide an audit of its internal claims processing/adjudication procedures in order to determine the accuracy of Contractor's claims processing/adjudication practices. Should any work be inaccurate, as determined by

Director, Director will notify Contractor within a reasonable period of time of such findings. Contractor shall correct any and all inaccuracies within ten (10) working days of receipt of notice of any errors and such correction shall be at no additional cost to County. In the event that Director finds that the errors have not been corrected by Contractor, the cycle of corrective action by Contractor and re-sampling by Director may, at Director's sole discretion, be repeated. Director will notify Contractor within a reasonable period of time of the re-sampling results.

11. Payment: Contractor shall bill County in arrears. The sole compensation to Contractor for services provided hereunder shall be as follows:

A. Emergency, Inpatient and/or Limited Outpatient Medical Services:

1) Set-up Fees: Contractor shall not receive a set-up fee.

2) Systems Modifications: Contractor shall receive a fee which shall not exceed $80 per programming hour or prorated portion thereof for periods less than one hour for revised or new programming requested by Director, the rate and process which the parties will use as described below:

a) Contractor shall submit to Director a quotation in writing for the projected work, including an estimated number of programmer hours for completion of the programming task.

b) Director shall determine the credibility of the estimate submitted by Contractor and, if necessary, revise the estimated number of hours requested for performing the programming task. Director shall apprise Contractor in writing of County's acceptance of the quotation or of the revised estimate within ten (10) calendar days of the Director's receipt of the quotation.

c) Contractor shall, upon completion of the work, submit an invoice to County with the actual number of hours that was required to complete the programming Task, not to exceed, however, the number of hours for completion for the task as approved by Director in accordance with Subparagraph (2) above, and prepare and keep detailed records of staff work and time spent on any programming task hereunder, and shall make them available for audit and photocopying upon

request by County representative pursuant to Paragraph 9 (Records and Audits) of this Exhibit.

3) Adjudication Fees: Contractor shall receive a fee of $3.15 for each manual (hard copy) claim and $1.65 for each electronic service claim adjudicated during a Fiscal Year resulting in payment to a MPP Physician by the County.

B. Handling Fee and Postage for Mailing Services: County will reimburse Contractor $0.015 per claim for handling fee and the additional cost of postage associated with the physical mailing described in Paragraph 4, Services To Be Provided, Subparagraph B, 22 of this Exhibit.

C. MAC Number and Hospital Patient Data Matching: Contractor shall not receive a fee for Medical Alert Center (MAC) number matching and/or hospital patient data matching for performance of adjudication services.

D. Printing Services: Contractor shall receive reimbursement for the costs of printing services (e.g. physician enrollment packages, PSIP newsletters, etc.)

E. Optional Services

1) Audit Nurse Specialist: Contractor shall receive a fee of $40 per hour or prorated portion

thereof for periods less than one hour for the services provided by an Audit Nurse Specialist, as described in Paragraph 6, Optional Requirements.

2) Medi-Cal Eligibility Matching: Contractor shall receive a fee of $1,000 per month to perform Medi-Cal eligibility matching, as described in Paragraph 6, Optional Requirements.

3) Medicare Eligibility Matching: Contractor shall receive a fee of $1,500 per month to perform Medicare eligibility matching, as described in Paragraph 6, Optional Requirements.

4) Data Reporting: Contractor shall not receive a fee for Data Reporting, as described in Attachment C-2, Conditions of Participation Agreement.

5) Providing Data to County Information Repository: Contractor shall not receive a fee for providing data for storage in County Information Repository, as per specifications described in Attachment C-11, AIA Record Layout.

F. Corrections: Corrections of any and all claims due to Contractor's errors, as determined by County, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing.

Should any work be inaccurate, as determined by County, Contractor shall promptly correct all inaccurate or unacceptable work to conform to the requirements of this Exhibit, in accordance with Paragraph 10, Quality Improvement, and the Attachments, or as otherwise determined by County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work is acceptable to County. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County.

G. Specified Time Period: County shall be liable to Contractor with regard to amounts payable to Contractor for services performed hereunder that fall within a fiscal year time period specified in the Agreement.

H. Invoices: Contractor shall submit a monthly invoice, in arrears, showing all claims processed and adjudicated, the amount of Medi-Cal/Medicare/Other Insurance eligible claims, and the costs for mailing services for the previous month of service. County shall pay all invoices within thirty (30) calendar days from receipt of complete and correct billing, as determined by CPM. County shall only reimburse Contractor for each

adjudicated claim that result in payment to MPP Physician by Director or Denied Medi-Cal/Medicare/Other insurance eligible claim.

In the event that Director requires Contractor to re-adjudicate any and all claims due to the year-end reconciliation process, County shall pay only for the programming cost to calculate the adjusted payment amount for each claim. County shall not pay the negotiated processing and adjudication fee per claim.

I. Accuracy of Work: Corrections of any and all claims due to Contractor's errors, as determined by Director, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County. Contractor shall promptly correct all inaccurate or unacceptable work to conform to the requirements of this Exhibit and Attachments at no additional cost to County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work is acceptable to County.